County of San Diego

JEAN M. SHEPARD
DIRECTOR

ALFREDO AGUIRRE
CHILDREN'S MENTAL HEALTH SERVICES
DIRECTOR
ADULT AND OLDER ADULT MENTAL HEALTH SERVICES
ACTING DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY

CHILDREN'S MENTAL HEALTH SERVICES
ADULT/OLDER ADULT MENTAL HEALTH SERVICES
P.O. Box 85524
San Diego, CA 92186-5524
(619) 563-2750/2700 • FAX (619) 563-2775/2705

June 28, 2004

TO: Mental Health Stakeholders

FROM: Alfredo Aguirre, LCSW
Acting Mental Health Services Director

CASE MANAGEMENT CONSULTANT REPORT FOR ADULT AND OLDER ADULT MENTAL HEALTH SERVICES

I am pleased to release the "Case Management Consultant Report for Adult and Older Adult Mental Health Services." This consultant report is part of our ongoing system redesign implementation strategy in integrating psychosocial rehabilitation practices into the system of care. I wish to express my gratitude to all of you who were key informants in this report. We were fortunate to have consultants who are familiar with best practices for individuals with serious mental illness. Their expertise is reflected in the breadth and depth of this report.

We plan to address the report's recommendations by establishing a work group that will prioritize the recommendations and consistency with rehabilitation and recovery practices, as well as for their feasibility with environmental demands. Some of the recommendations set forth in this report can be accomplished in the first year and others may have to be postponed until resources are available in the system. A process for approval of the prioritized recommendations will be identified within the next six months.

The work group will include consumers, family representation and direct service providers. For further information on how to participate in the work group, please contact Piedad Garcia, Ed.D., LCSW, Director, Adult and Older Adult Systems of Care at 619-563-2763.

Sincerely,

ALFREDO AGUIRRE, LCSW
Acting Mental Health Services Director

AA:kb
Attachment

County of San Diego

Health and Human Services Agency
Adult and Older Adult Mental Health Services

Case Management Consultant Report for Adult and Older Adult Mental Health Services

October 2003

Margaret Walkover, MPH
Robert Surber, LCSW

Prepared by:
Margaret Walkover, MPH
Robert Surber, LCSW

About the Consultants:

This document, "Case Management Consultant Report," was written by a team of consultants based in the San Francisco Bay Area. As a team, Margaret Walkover MPH and Robert Surber LCSW brought unique "hands-on" expertise and insight to this project in the areas of case management, adult system of care design, and wellness/recovery approaches.

- Since the inception of case management in the late 1970's, **Robert Surber** has defined, developed, managed, researched, described, taught and promoted *case management programs* for adults with serious mentally illnesses throughout the United States and Europe.
- For the past thirteen years, **Margaret Walkover** has played a key role in defining and implementing *Adult System of Care and Wellness/Recovery concepts* in public mental health services with the California Mental Health Directors Association, the California Institute of Mental Health and in collaboration with AB2034 programs and counties throughout California.

This team's approach to consulting is to support health and human service organizations to clarify and pursue their goals and to develop effective strategies to prioritize and implement these goals. This is done through fostering strong and positive relationships throughout the organization, within a process that clarifies and supports the organization's mission and values. Program development and system of care implementation activities are designed to build upon the strengths, traditions, culture, and historical context of the organization.

Acknowledgements

The insights and strategy contained in this report reflect feedback from several sets of stakeholders in the Adult Mental Health System. The report was strengthened through feedback and review by consumer leadership, Mental Health Services administration, case management administration and case management line staff.

The consultants want to acknowledge the unique and exemplary leadership and vision demonstrated in planning documents that told the story of previous efforts to analyze and change the San Diego mental health system. This Case Management report was built on the conceptual and pragmatic strengths of these efforts.

Finally, the consultants would like to thank Debbie Malcarne, LCSW, Psychosocial Rehabilitation Coordinator and the Project Manager for this effort, and Piedad Garcia, Ed.D., LCSW, Director, Systems of Care. Their support and feedback during the research and production phases of this report has been critical to the consultants' efforts.

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EXECUTIVE SUMMARY

The objective of this report, "Case Management Consultant Report," is to suggest strategies to further develop and enhance mental health case management services for adults and older adults in San Diego County. To achieve this, the consultants completed an assessment of case management services and offer eight sets of recommendations to support the development of a case management strategic plan for the San Diego Adult/Older Adult Mental Health Services (AMHS).

This report begins with an introduction and then provides a review of case management history, issues and definitions; a vision for a comprehensive mental health treatment system; an assessment of case management services and the system of care; and recommendations for system change in case management including further developing case management programs, the system of care and the leadership culture within AMHS.

A critical assumption in this report is that case management is the central focus of treatment for a client population that is the primary responsibility of public mental health services systems. Yet case management client outcomes depend on much more than a case manager. Client outcomes are also influenced by the effectiveness of and collaboration with the entire mental health system, other health and human services, and an array of formal and natural community supports. As a result, the report's recommendations are based on a definition of case management as integrated and comprehensive treatment, and suggest that all programs in the mental health system share responsibility for implementing services within an integrated comprehensive treatment model of care.

This report's recommendations, listed below, provide both broad direction and specific steps to further develop case management and the system of care within San Diego County Adult and Older Mental Health Services. These recommendations are comprehensive in their scope and build upon the many strengths of the AMHS System of Care. The following eight sets of recommendations are consistent with the psychosocial rehabilitation (PSR) approach that has been adopted by the county and address: improving case management services; rethinking the design of the system of care; integrating case management services with the system of care; and streamlining and strengthening the leadership structure throughout the system of care.

Summary of Case Management Consultant Report Recommendations

SET	TOPIC
Set 1	**Consensus Development: Vision for an Integrated Regionalized Mental Health System** 1.1 Convene a stakeholder group to develop a consensus that supports an integrated, regionalized system of care
Set 2	**Establish a Case Management Definition** 2.1 Adopt a county wide definition for case management services
Set 3	**Reprocure Contracted Case Management Services** 3.1 Incorporate recommendations designed to improve the effectiveness and efficiency of case management services (Set 6) into the RFP used to reprocure new contracts. 3.2 Evaluate Transitional Case Management programs
Set 4	**Restructure the County Case Management Program** 4.1 Explore the feasibility of integration of county case management staff into outpatient clinics.
Set 5	**Develop Low-Intensity Case Management Capacity in Outpatient Services** 5.1 Provide low-intensity case management services in county outpatient clinics 5.2 Provide training to outpatient clinicians and clinic leadership on case management roles 5.3 Provide individual and group supervision for clinicians providing case management services 5.4 Utilize county case management staff to consult and supervise outpatient clinicians prior to integrating staff into clinic settings
Set 6	**Improve the Effectiveness and Efficiency of Case Management Services** 6.1 Strategies to increase effectiveness of current case management programs (program design strategies) 6.1.1 Implement evidence based programming 6.1.2 Improve capacity for strategic decision making 6.1.2.1 Establish a committee to develop a unified vision for case management programs and monitor the planning and implementation process. Include administrators and line staff from contract, county and outpatient services. 6.1.2.2 Encourage program managers and administrative staff to provide or supervise direct case management services 6.1.2.3 Establish measurable and relevant performance standards 6.1.2.4 Design report cards for all case management programs 6.1.3 Integrate medication treatment into case management services 6.1.4 Provide hospital privileges for case management psychiatrists 6.1.5 Provide Transitional case management services for START clients 6.1.6 Provide Case management access for homeless clients 6.1.7 Develop partnerships with families and support system members 6.1.8 Develop opportunities for client employment 6.1.9 Employ consumer in all case management programs 6.1.9.1 Establish peer counseling training program 6.1.9.2 Consult with other counties about how to develop successful consumer employment organizational culture 6.1.10 Improve case management training opportunities 6.1.11 Increase case manager's capacity to work with dually diagnosed clients

	6.1.12 Increase access and integration with services that case-managed clients need and use 6.1.13 Develop an appeal process for long term care placements 6.1.14 Re-establish the liaison role of county case managers 6.2 Strategies to increase the efficiency of current case management programs (resource utilization strategies) 6.2.1 Restructure case load size 6.2.2 Reduce paperwork burden 6.2.3 Increase tools for case managers
Set 7	**Improve the Integration of Case Management Services with the Mental Health System (service level integration)** 7.1 Psychiatric hospitals and emergency psychiatric units 7.2 Residential care/independent living facilities 7.3 Primary care 7.4 Community resources 7.5 Communication and coordination between staff and programs
Set 8	**Strengthen the System of Care – (funding and leadership)** 8.1 Plan and strategize to develop funding 8.2 Strategy for community support 8.3 System of care leadership development 8.3.1 Integrate case management providers in regional provider meetings and/or establish regional case management provider work groups 8.3.2 Continue to develop a wellness/recovery task force via the PSR Advisory Work Group. 8.4 Consumer/family leadership development 8.4.1 Identify consumer/family roles in the system of care 8.4.2 Establish a plan to reimburse consumers/family members for costs associated with attending meetings 8.4.3 Provide training to support effective committee participation

The process for preparing this assessment and recommendations involved extensive data collection that included reviewing planning documents prepared by AMHS over the past several years, mental health program descriptions and various data-based reports. Data collection also included conducting stakeholder/focus group interviews that involved discussions with administrators, program managers, case managers, providers of other mental health services, advocates, consumers, and family members.

A process for consideration, adoption and implementation of the report and its recommendations is included as part of the recommendations. This process seeks to build on the pre-established committee structure within AMHS with an eye towards strengthening the leadership base from central administration through the line staff level. The recommendations in this report also seek to enhance the critical roles of consumers, family members, and staff from non-mental health agencies that provide services to clients.

Case Management Consultant Report

I. INTRODUCTION

This report provides an assessment and recommendations to support a case management strategic plan for the San Diego Adult/Older Adult Mental Health Services (AMHS). The report includes a discussion of the current state of case management services, a vision for a state-of-the-art regional based mental health service system, an assessment of existing case management services and the system in which they work, and recommendations for further developing both case management programs and the system of care.

A) Background

The San Diego Board of Supervisors approved the System Redesign Plan for the Adult/Older Adult Mental Health System in 1999. This plan envisioned competitive reprocurements as a means to "realize system redesign goals and move from a traditional clinic-based model of treatment and care to one of psychosocial rehabilitation and recovery" (pg. 68). Initial reprocurements were recommended for specific regional core services (outpatient, outreach, day rehabilitation), followed by case management services.

The "Case Management Services Workgroup Report" was completed in FY 2000 to further refine the System Redesign Plan on the topic of case management reprocurement. This workgroup report defined clinical case management as a key component in the county's approach to implement the psychosocial rehabilitation approach to treatment and care. In early 2003 a competitive process resulted in awarding a contract to an independent consulting firm. The objectives of this contract included: a description and assessment of the current state of case management services; recommendations for case management and system of care design that would support a case management strategic plan; and recommendations on the reprocurement of contracted case management programs. The expectation was that recommendations would take into consideration previous system redesign efforts.

B) Developing the Assessment and Recommendations

The process for preparing this assessment and recommendations involved extensive data collection that included reviewing previously prepared plans and program information and data. It also included conducting stakeholder/focus group interviews. These occurred during a visit from March 26-28, 2003 and involved discussions with administrators, program managers, case managers, providers of other mental health services, consumers, and family members.

The consultants met with a total of 156 individuals as documented in the following table:

Table 1: Who Participated in Stakeholder Interviews and Focus Groups? Percentage Breakout by Cohort

Cohort	Percentage of Total n=156
Mental Health Administration Stakeholder Interviews	(10) 6%
Case Management Focus Groups • Administration • Case Management Line Staff	 (13) 8 % (36) 23%
Consumer/Advocates Focus Groups (and one stakeholder interview)	(46) 29%
Family Members/Advocates Focus Groups	(5) 3%
"Other Providers" Focus Groups	(46) 29%

C) Approach to Case Management Services

The consultants suggest that the term case management be defined as an approach to integrate comprehensive treatment interventions for a population with multiple needs. The recommendations in this report are consistent with the county's direction to regionalize services and clear commitment to integrating psychosocial rehabilitative principles into the delivery of mental health services.

The approach in this report is that case management services have been established to integrate services for clients and their families with the objective of supporting wellness, recovery, and full functioning as community members. This approach acknowledges that case management services are only as effective as the delivery system in which they are embedded. The Strategic Case Management Plan will incorporate recommendations for system of care strategies and programs designed to enhance the effectiveness of the Adult/Older Adult System of Care.

The report recommends strategies to implement a state-of-the-art case management service system that builds upon the strengths, cultures, and traditions of the San Diego County Mental Health Services and the clients and families it serves. It addresses the following topics:

- Case Management History, Issues, and Definitions
- A Vision for a Comprehensive Mental Health Treatment System
- Assessment of Case Management Services and the System of Care (this section includes recommendations)
- Recommendations to support a Case Management Strategic Plan

D) Summary of Recommendations

This report's recommendations build on the innovations currently available in the San Diego Older Adult/Adult System of Care. In addition, the report addresses system challenges, and incorporates the psychosocial rehabilitation philosophy that has provided the catalyst for systems change since the adoption of the System Redesign Plan in 1999. A summary of the recommendations, described fully in Section IV of this report ("Assessment of Case Management Services and the System of Care"), can be found below.

Table 2:
Summary: Recommendations To Support the Development of a Case Management Strategic Plan

SET	TOPIC
Set 1	**Consensus Development: Vision for an Integrated Regionalized Mental Health System** 1.1 Convene a stakeholder group to develop a consensus that supports a integrated, regionalized system of care
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II. CASE MANAGEMENT HISTORY, ISSUES, AND DEFINITIONS

A) A Brief History of Case Management

In the 1960's there was a widespread movement throughout the United States to treat people with serious mental illnesses in the community rather than in State Hospitals. This later became known as the de-institutionalization movement, and grew out of a confluence of factors including the availability of antipsychotic medications, awareness of the debilitating effects of institutionalization, publicity about the abysmal conditions in many State Hospitals, and the availability of Federal funding for community based mental health centers.

By the early 1970's it was clear that there were many individuals with serious mental illnesses who had been released from long-term hospitalization that were failing in the community. This was evidenced by high rates of recidivism in acute psychiatric hospitals, high rates of homelessness and criminal justice incarceration for this population, and inordinate burdens placed on families who were struggling to care for their mentally ill family members.

To address these problems, the Federal government established the Community Support Services Initiative that asked experts from around the country to describe the services that were needed for severely mentally disabled individuals to succeed in the community. The results from the process, in 1978, described an array of mental health treatment services and other supports that are needed within a community based system of care. This process also acknowledged that many individuals were too disabled to access all of the services they needed, that were often provided within multiple and fragmented service systems. Therefore, this Community Support Services Initiative described the role of a case manager who would be responsible for assuring that clients received all of the services that they needed. (Turner, et al., 1979)

Case management was originally described as incorporating five functions that included: assessment, planning, linkage, monitoring, and advocacy. This represented a new role that was necessary to integrate the multiple services needed by mentally ill individuals. In the initial concept of case management, this role did not include mental health treatment. Rather, case managers linked clients to treatment and supportive services. Therefore, case managers were generally not required to have clinical training. This non-clinical model is now referred to as brokerage case management.

Some mental health program developers believed that the concept of case management, as initially described, was a helpful breakthrough, but incomplete to meet the needs of seriously mentally ill populations. First, the case manager role requires an ongoing relationship with clients. This can be difficult to achieve when a significant disability experienced by the target population is an inability to

establish and maintain interdependent relationships. Therefore, case managers needed a skill set to engage clients and maintain relationships. Second, when case managers were able to engage clients into a productive relationship, it was often not possible to link clients to mental health treatment services because of obstacles presented by both clients and providers.

This led to the concept of clinical case management that incorporated a clinical staffing pattern. Under this model, Clinical Case Managers provided all of the functions originally described for the case management brokerage role plus clinical and other treatment interventions. The idea that case management could be integrated with treatment and could be delivered in a multidisciplinary team setting started to take form. Most clinical case management programs incorporate psychiatrists and nursing personnel to integrate psychopharmacological treatments into the clinical case management program. (Kanter, 1989; Surber, 1993) Proponents of Psychosocial Rehabilitation services added a case management role for clients and introduced recovery concepts through rehabilitation oriented skill-building programming. (Anthony, 1993)

Parallel to the development of case management programming, the Program for Assertive Community Treatment was established and evaluated in Dane County Wisconsin, and later replicated throughout the world. This model used a team approach to provide comprehensive treatment and supportive services to a clientele experiencing serious mental illnesses. The staff in what are now commonly called Assertive Community Treatment (ACT) teams often have a working title of case manager. (Stein & Test, 1980)

In most of the case management models an individual case manager typically serves a caseload of clients. While ACT programming uses a team approach, it is suggested here that a team or individual approach can be used to implement the same concept of comprehensive and integrated community based treatment.

Throughout this period other models and terms have been used in association with case management. For example the *Strengths Model* of case management focuses on building on client strengths rather than on pathology. The term *Intensive Case Management* usually describes programs that have small caseloads.

Specialized Case Management approaches provide the expertise needed to engage and treat specific target populations in the context of comprehensive services. A number of mental health systems have developed Specialized Case Management programs, and some systems have dedicated their ACT programs to the needs of specific populations. Common examples of specialized case management programs include: geriatric teams, dual diagnosis teams (mental health and substance abuse services), transition-age youth programs, programs for forensically involved individuals, and wraparound programs for youth.

Another method of providing specialized case management services is to embed staff that can respond to particular client needs into a generalist case management team. Examples include: housing specialists, dual diagnosis specialists, employment specialists, and mental health consumers hired to provide peer recovery services in a peer support or case management role.

Some jurisdictions have also implemented *Transitional Case Management programs* that provide short-term services (up to 90 days) that are specifically designed to link clients being discharged from acute and long-term hospital settings to community services.

B) Current Issues in Case Management

Over the past 25 years case management programs have proliferated in mental health service systems throughout the US and Europe. Most public mental health services systems have a number of case management programs that have developed over time to serve different populations with different program models. There are a wide variety of program designs and expectations for case management services. For example, caseload sizes for providers with the title of case manager range from six to 600 individuals. Many mental health systems have developed case management services with different levels of intensity to respond to different levels of client need. Additionally, some case management programs provide services of indefinite duration, and others have been developed to provide transitional programming for only a few months.

There are a number of considerations and issues related to the discussion on the development and value of case management for a population with mental illnesses.

1) Access to Case Management Services

The most significant problem associated with case management services in most public systems is its unavailability to many who need it. Because of the high costs associated with case management, these services have been reserved for the highest need and most expensive clients. While this is a rational response to limited resources it creates an untenable situation in which many people who need the service must wait years, become multiply hospitalized, and/or incarcerated, and/or addicted, and/or become more distrusting and difficult to engage, and/or burn out their support systems before receiving adequate care. Obviously, the individual, social, and public costs of this situation are extremely high.

At the same time, there is growing evidence from abroad that early intervention strategies for psychotic disorders results in significantly improved outcomes, and dramatically reduced costs. It has been well established from multiple studies in the US and abroad that a long duration of untreated psychosis (DUP, which is

defined as the time from which psychotic symptoms occur until effective treatment is initiated) is associated with much worse long-term outcomes on a variety of variables. (Larsen, et al., 2000) This argues for treatment based on case management concepts being broadly available and as soon as psychotic symptoms emerge, and for a population that is much wider than for that which it is currently provided.

2) Long-Term Relationships Versus Program Transitions

A key unresolved issue in this field is an issue raised by the evidence that effective case management is based on long-term relationships with providers. Many case management programs are designed to provide services of indefinite duration. However, many clients in these programs improve and no longer need the intensity of services that they previously required. Some may only need medications, occasional check-ins, and additional support in times of crisis. Transferring these more stable clients to another program defeats the purpose of maintaining long-term relationships and, in fact, frequently destabilizes clients.

The problem for public systems is that the most intensive and costly community based programs eventually have a large caseload of relatively stable individuals and are not available to serve a continuing stream of recently hospitalized and high need clients.

There is yet to be a satisfactory resolution of this issue that has been implemented to date. However, in a 1996 report to the Federal government on case management standards in managed mental health systems, the National Association of Case Management (NACM) proposed that case management programming include three levels of intensity:

- Level I- Provides extensive support to the most disabled with staff/client ratios of 1 to 10, and includes 24/7 crisis support (similar to ACT)
- Level II- Provides recovery/rehabilitation focus for clients who are recently stabilized in the community with staff/client ratios of caseload 1 to 20 and the availability of 24/7 crisis support. (Similar to Intensive Case Management)
- Level III- Supports self-management with staff/client ration of 1 to 60 with on call availability during evenings and weekends. (Similar to a model suggested by Len Stein, a co-founder of PACT, who suggests that one physician and 4 nurses could serve 200 clients who have been stabilized by ACT service teams)

The NACM hypothesized that each of these levels could be delivered within the same program so as to avoid the problem of transferring clients among service levels. (Hodge & Geisler, 1997)

3) Case Management Outcomes

The research literature on case management for seriously mentally ill populations has consistently found positive outcomes for case management programming in terms of reduced hospitalization, and increased family and consumer satisfaction with treatment. In addition, no negative outcomes have been associated with case management services. (Chamberlain & Rapp, 1991)

Case management programs demonstrating these outcomes have had relatively low caseloads (a staff/client ratio of 1 to 25 or less), a focus on long-term relationships (of indefinite duration), and incorporate treatment (especially medications) into the service.

While these are significant and important outcomes, they do not speak to the central issue of treatment and how it improves the quality of life of mental health consumers. In a variety of quality of life domains, case management evaluations almost never show worse results but often do not demonstrate better outcomes than traditional outpatient treatment. This suggests the need for further development of case management technology that focuses on quality of life issues. (Mueser et al., 1998)

Currently there are a number of program elements that have been incorporated into case management services. There is evidence that each of the following program elements improves outcomes:

- Employment (per the Individualized Placement Services model),
- Housing
- Formal Skill Building Group Interventions,
- Multi-Family Psychoeducational Groups,
- Substance Abuse Treatment
- Primary Care, and
- Peer Support

Transitional (short-term) case management programs have not demonstrated the outcomes achieved in long-term case management services. It is the experience of many of these providers that they are able to engage many clients into a relationship and may assure initial housing stability, but clients are not often linked to ongoing treatment and support that can sustain their efforts.

4) Incorporation of Wellness/Recovery Concepts into the Case Management Models

Possibly the most important development that will support clients full integration into the community and their quality of life in case management programs is the implementation of wellness and recovery concepts. Historically, the focus of most treatment efforts, and case management programs in particular, has been to reduce symptoms, maintain clients in the community, and avoid deterioration,

because this was believed to be all that was possible for seriously disabled mental health clients.

This belief has been proven to be incorrect, and it is now known that many clients experiencing psychotic disorders can recover and live full and productive lives**.** (Deegan, 1988; Fischer, 1991, Frese & Davis; 1997, and McGuire, 2000) It is also understood that it is not possible to predict, based on history, which of these individuals will recover and which will continue to require long-term structure and intense supports. The challenge for mental health services systems at this time is to provide opportunities for client recovery while continuing to provide a safety net for those who do not appreciably improve.

Services that focus on wellness and recovery are based on a series of principles. While different authors describe a somewhat different approach, the following are principles that are commonly considered as appropriate for programs for adults and youth. These principles suggest that care should be organized so that it is:

- *Comprehensive* – Utilizing a wrap around model that includes implementing a comprehensive assessment of clients' and families' needs as well their personal goals and wishes.
- *Integrated* – At the client level this involves implementing a single point of responsibility role to develop an integrated service plan to meet all of their needs. At the service level this involves supporting system of care development and coordination.
- *Individualized*– Providing services that respond to clients' specific needs and in a manner acceptable to each client.
- *Flexible* – Including the ability to serve clients in a unique manner, based on their particular needs and wishes. Flexibility also means that staff and programs are flexible in the services they provide and the manner in which they are offered.
- *Culturally Competent* – Including providing services in clients' primary languages with a bicultural staff that honor the clients' cultural heritage. This also includes providing access to culturally based complimentary healing practices, and culturally appropriate activities, including opportunities for cross cultural experiences. Within this approach culture is acknowledged as a strength that offers resources to support the service plan.
- *Client Centered* – Services focus on the clients' and families' definition of their goals and needs. The clients determine what services and resources they will use and how they will use them. Clients and families actively participate in developing their service plan and its implementation.
- *Community Based* – Clients are engaged, treated and served in natural community based settings that they use and where they congregate such as their homes, schools, recreation centers, and other community settings. All resources of the community are utilized for providing wraparound supports.

- *Family Focused* -- Services are provided concurrently to clients and their families. In addition to treating individuals, the goals of care include improving relationships among family members, supporting parents in strengthening their parental roles and supporting all family members in identifying and pursuing their life goals.
- *Strengths Based* – Services assist clients and families to identify and build upon their unique strengths and resources to pursue their personal goals as they define them in their treatment plan.
- *Collaborative* – Services are provided in collaboration with other providers and individuals who have an interest in the clients and their families.
- *Cost Effective* – Services are designed to be cost-effective by integrating an array of interventions that reduce costly institutional care.

5) Integration of Care at Multiple Levels

It was noted above that the intention of case management is to integrate treatment and care for a multiple need population. It is also suggested that integration is needed at three levels, including the individual client level, the service level and the policy level.

Case management services work to integrate services at the client level through providers who represent a single point of accountability with responsibility for developing a comprehensive assessment and implementing a treatment plan that focuses on client goals and responds to all of the issues identified in the assessment.

However, case management services can only be as effective as the system of care in which they are imbedded, and as policies and funding requirements allow services to be provided in the most effective manner. This speaks to the need for strategies to integrate services at both the service and policy levels. In recent years, some mental health jurisdictions have worked on strategies to better integrate their service systems. In California, the Adult System of Care (ASOC) Framework approved in September 2000 by the California Mental Health Directors Association is an effort to describe a process for integrating care at this level. The need for integration at the policy (e.g. funding) level is understood to be necessary, but to date these efforts are more theoretical than practical.

C) Defining Case Management as Comprehensive Treatment

Despite the growth and universality of case management programs, there is little shared understanding as to what the term case management means, and no consistency as to how it is implemented. For some, case management means a fully comprehensive and integrated treatment model (such as generally implemented within ACT teams), and for others it denotes referral activities that are adjunctive to outpatient treatment (as delivered by therapists who are care coordinators). While the original concept of case management was to have a

single person (or team) who would be responsible for a comprehensive assessment and for developing and implementing an integrated service plan, a client may now have several providers in numerous programs who are called case managers or who bill for case management services. These case managers usually have different responsibilities and expectations. In addition, many people believe that the words case and management are not appropriate to the role of a case manager or the goals of mental health treatment. In summary there is no clear definition of case management and the term is objectionable to many.

It is suggested that the term case management be defined as an approach to integrate comprehensive treatment interventions for a population with multiple needs. This is consistent with the Clinical Case Management concept that was adopted by in the San Diego County "Case Management Services Workgroup Report" (May 2000), and the ACT teams that the county has established in recent years. From this perspective Clinical Case Management and ACT models are merely different structures (i.e. individual provider versus team model) to implement the same concepts for a clientele with differing intensity of needs.

The concept of comprehensive treatment is consonant with the original definition of case management in that these programs provide a single point of accountability for developing a comprehensive assessment with the client and implementing an integrated service plan to meet the clients' needs and to support their life goals. Comprehensive treatment programs also specifically define themselves as the primary locus of treatment (a "clinical home" for the client) and integrate an array of specific clinical interventions, as well as linkage to other community resources to implement the service plan.

For this discussion the terms comprehensive treatment and case management will be used interchangeably. This is because the term comprehensive treatment most accurately describes the expectations of what are now commonly referred to as case management services. Currently there are a number of common elements that are considered to be the hallmarks of state-of-the-art comprehensive treatment programs. These include:

- Actively engaging clients into a trusting relationship
- Accepting responsibility for maintaining clients in the program
- Providing services of indefinite duration
- Providing services in community and office based settings as most appropriate
- Having caseload sizes that are appropriate to client needs and the expectations of the role
- Balancing services to clients with services to families and natural support system members and supporting access to community resources
- Titrating support as client need changes
- Incorporating mental health consumers as direct service staff
- Providing 24 hour/7day per week access to services

- Incorporating psychosocial rehabilitation, and wellness/recovery principles

The literature on comprehensive treatment models suggests that the best outcomes are achieved in programs that integrate services into the program and limit the need to refer clients to other providers to meet their needs. (Allness & Knoedler, 1998) Specifically, the interventions that are integrated into comprehensive treatment programs are evidence-based practices that include the following:

- Psychotherapeutic Interventions — to support clients in defining their goals, improving social relationships, define meaning in their lives, clarifying choices, and accepting responsibility for their own recovery. Clinical interventions may be provided through formal office-based psychotherapy by the program staff or by referral to an outside therapist. The clinical case management approach suggests that clinical interventions are integrated within the delivery of all services. (Balancio, 1993)

- Psychopharmacological Treatment – to integrate medication treatment with all other interventions. Psychiatrists and nursing personnel who can prescribe and administer medications are integrated into the program. (Jones, 1993)

- Peer Support – to provide role modeling, hope, and support for engagement from individuals with whom clients can identify and more readily trust. This is made available through hiring clients who provide services within the case management program and through linkage with consumer-managed alternative programming. (Campbell & Schraiber, 1989; Felton, et al., 1995)

- Psychoeducation – to clients, family members, community members, and other providers to increase understanding of mental illnesses and their treatment, as well as strategies for managing symptoms, using the mental health system, and accessing other resources. (McFarlane, et al., 1995)

- Environmental Support – to assure that clients have access to all of the supports needed for successful community life including entitlements, housing, primary care, dental services, recreational opportunities, legal services, educational programming, etc. (Surber, 1993a; Rosenheck, et al. 1998)

- Integrated Substance Abuse Treatment – to respond to the high prevalence of substance abuse disorders among seriously mentally ill populations. The most effective model uses a phased substance abuse treatment approach that is provided concurrently by the same staff who

provide mental health interventions. (Minkoff, 1989; Fariello, 1993; & Drake, 1996)

- Psychosocial Rehabilitation Focused Skill Building – to respond to the need for clients to learn specific skills necessary for successful community living. This occurs through a range of interventions that include staff teaching clients to shop or cook or use the transportation system *in vivo* in the community and formal group-based skill building programming that occurs in clinical settings. (Anthony, 1993; Liberman 1993)

- Supported Employment Services – to respond to clients' primary goal of wanting a competitive job. The most effective model is the Individualized Placement Services approach that has been demonstrated to be the most successful at obtaining competitive employment for seriously mentally ill populations, and is specifically designed to be integrated into case management programs. Becker & Drake, 1993; Becker & Drake, 1994; Becker, et al., 1998, and Bailey, et al., 1998)

- Partnerships with Families – to educate and support families so that they are better able to support their mentally ill family members. This is achieved through a variety of formal and informal strategies. The model that has been demonstrated to be the most effective at reducing hospitalization is the use of Multi-Family Groups that include both family members and clients in a format that involves both didactic presentations and group support. (Hatfield, 1978, Lefley & Johnson, 1987; Scheidt, 1993, McFarlane & Deakins, 1994)

- Primary Care Services – to respond to the high medical morbidity rate of individuals with serious mental illnesses, and their lack of access to primary care services. This includes traditional medicine as well as complementary approaches, such as acupuncture and herbal medicines, that many mental health consumers find helpful. While few mental health case management programs in the US directly provide primary care services, client outcomes are improved when consumers have access to responsive medical care. (Crew, 2003)

- Spiritual/Religious Support – to respond to the consumer survey that indicated that over 60% of mental health clients stated that the most important element of their recovery was their religious beliefs. The role of comprehensive treatment is to assess clients' interest in pursuing religious activities or a spiritual path as part of their recovery, and supporting them in doing so. (Mahler, 2000)

III. VISION FOR A COMPREHENSIVE MENTAL HEALTH TREATMENT SYSTEM

Introduction

Case management services are the locus of care for seriously mentally ill individuals in a contemporary mental health system. Recommendations about how to structure and further develop these services need to be based on a clear conceptualization of the overall system of care.

San Diego County's effort to integrate Psychosocial Rehabilitation (PSR) into its Adult/Older Adult System of Care provides a foundation from which the programmatic and leadership components of this conceptualization can be developed.

The consultants observed that over the past years, San Diego leadership has made a concentrated and laudable effort to integrate the principles of psychosocial rehabilitation into its delivery system and into the day-to-day practice of providers. This effort started with the consultation of Bill Anthony from the Center for Psychiatric Rehabilitation, Boston, in FY2000, followed by the conscious inclusion of wellness/recovery training and programming into the six HHSA/AMHS service delivery regions. In this regard, San Diego is among a handful of counties that have systematically attempted to develop a wellness/recovery infrastructure within their county.

San Diego's effort to develop a wellness/recovery philosophy and infrastructure is reflected in the following list of initiatives observed in this consultation. The first seven items on this list are unique to San Diego's leadership and have not been as thoroughly implemented by most of California's counties:

- Developing and supporting a regional clubhouse system
- Supporting PSR training for all personnel.
- Planned efforts to include recovery oriented programs with a peer-support component into each region (WRAP, SanDMAP)
- Producing planning documents that clearly articulate a PSR vision and address system transitions.
- Successfully administering an AB2034 program that has developed a statewide reputation for excellence.
- Creating central administration staff positions dedicated to housing, transportation, employment/education, older adults, and psychosocial rehabilitation.
- Reprocurement of regional contracted core services to integrate psychosocial rehabilitation and recovery practices in the delivery of care
- Mental Health Director holds regular meetings with client leadership

- Centralizing the administration of contracted services while preserving an intention to honor regional innovation. The wellness/recovery approach is best nested in an organizational culture that promotes local innovation and decision-making, combined with clear leadership from the "top" of the organization.

Changing organizational culture is a task with a long horizon. San Diego is integrating a medical model mental health system with a psychosocial rehabilitation and recovery philosophy and practice. Not unlike other California counties, San Diego struggles with the challenge of "how-to" integrate the rehabilitation and-recovery approach at the mid-management and line staff levels. The success of the San Diego case management system will depend, in part, in San Diego's ability to integrate a wellness/recovery vision into the practice of its providers and the operations of its system of care.

With this in mind, the consultants offer some perspectives from a nine county Wellness Recovery Collaborative organized under the auspices of the Greater Bay Area Mental Health Directors. Counties in this Northern California region are using the Collaborative to systematically integrate psychosocial rehabilitation and wellness and recovery approaches and services into their adult systems of care. During its April meeting, members of this Wellness Recovery Collaborative agreed that Adult Systems of Care require three levels of effort to catalyze the integration of PSR into service delivery.

First, develop peer-to-peer and client-to-provider relationships that embody the recovery philosophy. Everyone in the system (from clients, providers, and family members to administrators and receptionists) needs to hold a vision of recovery that is based on honoring self-agency and making client choice possible. This vision is essential to support the day-to-day and moment-to-moment decisions that affect client recovery in the personal, service delivery and program administrative spheres. Examples of how this "level of effort" is effectively operationalized include: the inclusion of consumer employees at all levels of the delivery system; collaborating with the consumer community to sponsor WRAP trainings; support for clubhouses and other kinds of self-help centers; staff trainings and dialogues that foster discussion about wellness/recovery; speakers bureaus that feature clients in recovery along with providers and family members; and the integration of clinical tools that include a wellness/recovery orientation such as intentional care standards, motivational interviewing and the Texas Implementation of Medication Algorithms (TIMA).

Second, develop the presence of tangible pathways through the delivery system. Tangible pathways include supported education, supported housing, supported employment, clubhouses and an infrastructure for peer support/peer counseling. These services and supports are a clear

signal that the adult system of care is designed for more than the maintenance and stabilization of clients. These pathways might also include "doorways" that can be used as tangible exits from the system and as re-entry points into the system. These doorways, which often take the form of wellness/recovery centers, have been developed by Contra Costa and Stanislaus County and are on the drawing boards of several other mental health departments across the state. Wellness Recovery centers are used by clients in all stages of transition in the mental health system and may include "meds only" services, WRAP groups, employment, housing and education support.

It is inspiring for clients that are learning about recovery to be in contact with others who have learned to manage symptoms and relapse and are living in the community. Wellness Recovery centers include support groups for clients who live independently in the community and are not using case management services. These centers may also sponsor mentorship programs for clients who have returned to the community and want to provide peer support to clients that are entering the system.

Third, convene a Wellness/Recovery Task Force. The purpose of this task force is to create a space where a broad cross-section of system leadership can articulate a common vision and language for how wellness/recovery is manifested within the system of care. After the common language and vision is established, priorities can be set for: systematically developing multiple pathways of recovery into the system of care (i.e., housing, education, employment, peer support); integrating the consultation of consumers and family members into system redesign and programmatic decisions; and helping contract and county agencies find appropriate ways to adopt recovery approaches into their organizations. The work of a wellness/recovery task force would complement efforts to improve the case management system and the environment in which it operates. This task force might be built from the planning efforts of the PSR Advisory Group.

A context for all other system changes is created by the combination of these three levels of effort:

- "Top-down" leadership with a wellness/recovery task force;
- Making pathways tangible and available to support clients as they recover; and
- The "bottom-up" cultural infusion brought by recovery-oriented peer-to-peer and client-to-provider relationships.

This consultation is offered, in part, to support the strategic thinking required before a possible reprocurement of case management services. The vision described in this section of the interim report is based on the findings of this consultation. It builds from observed strengths and opportunities within the San

Diego mental health services system. The vision offers a picture of how case management services might be better organized and fit into the system of care. This vision can be used to guide discussions and decision making around reprocurement.

The following vision is intended to stimulate discussion for a comprehensive integrated mental health system for San Diego County. The proposed vision and recommendations in this report are consistent with the current redesign plans for the county and with the vision of the AMHS Executive Team. This vision assumes that implementation will involve redistribution of resources and additional resources within a multi-year time frame.

The "San Diego County System Redesign Implementation Plan for Adult and Older Adult Mental Health Services (AMHS)," prepared in 1999, directs the Health and Human Services Agency division to establish an integrated regional mental health system with funding parity among the regions. The AMHS 2002/03 Business Plan Refresh confirms this intent and states the following goals:

- "Establish and implement biopsychosocial rehabilitation and recovery principles and practices throughout AMHS services
- Continue developing the regionally integrated service system while working toward regional funding parity
- Expand services and augment existing services as funding becomes available
- Develop and implement an enhanced AMHS administrative and service delivery infrastructure

A) Developing an Integrated Regional Based Mental Health System

San Diego is a very large county both in terms of population and geography. It is also very diverse with a large Latino population and significant representation from numerous other ethnic groups. These factors support the development of regional mental health services. It is easier to integrate services in geographically discrete regions with smaller populations. It is also possible to develop culturally focused programming in regions in which there are large congregations of particular ethnic populations.

For this discussion it is suggested that San Diego County continue the development of psychosocial rehabilitative centers or Comprehensive Mental Health Recovery Outpatient Centers in the regions that are subject to reprocurement of services (Central, North Central and South). The central focus of these psychosocial rehabilitative centers or Comprehensive Mental Health Recovery Outpatient Centers would be to provide a "clinical home" for providing integrated care in the region. In addition, the leadership in the region would be charged with the responsibility of integrating the services of the Comprehensive Recovery Centers with other health and human services and local community resources.

B) Establishing Comprehensive Mental Health Outpatient Recovery Centers

Comprehensive Mental Health Outpatient Recovery Centers represent an emerging model in public mental health services development. Stanislaus and Contra Costa Counties have well-established comprehensive recovery centers (called Wellness/Recovery Centers) that function similarly to the description found below. Wellness/Recovery centers are on the drawing boards of several counties across California. San Diego has begun to form Biopsychosocial Rehabilitation (BPSR) Centers, which relate to this concept. The organizational form and structural details of an Outpatient Recovery Center will need to be further developed for optimal implementation in San Diego County.

The central concept is that the Biopsychosocial Rehabilitation Center or Comprehensive Recovery Center will provide care based on a comprehensive treatment approach for all clients meeting eligibility criteria for public mental health services. This would include treatment for individuals who only require brief individual and/or group treatment to meet their needs as well as those who require ACT and intensive case management services. The center might include distinct case management teams at the levels of intensity described above. However, all outpatient services would be based on wellness and recovery concepts. All outpatient clinicians who are care coordinators would be expected to provide services in community settings when that is most appropriate. In addition, they would have responsibility for implementing or providing any intervention (in addition to psychotherapy and medications) indicated in the treatment plan. The center could also be an additional or alternate resource for the large number of clients currently served by the fee-for-service psychiatry sector, providing more breadth of services when indicated.

The advantage of a center that provides all outpatient services is that programming can be provided at all levels of need within a single setting. This expedites the transitioning of clients to different levels of care as their conditions improve or worsen. It also makes it possible to efficiently integrate a menu of specific services that would be available to clients at different levels of need. The services that would be provided within the centers might include:

- Case management at several levels of intensity
- Psychiatric Medication Services (SanDMAP model)
- Psychotherapy (including CBT and DBT approaches)
- Integrated Substance Abuse Treatment [incorporating the Comprehensive Continuous Integrated System of Care (CCCISC)]
- Peer Counseling/Support in all treatment modalities
- Multi-Family Groups and other efforts to develop partnerships with families including psychoeducational approaches with families and other natural support system members
- Culturally Focused services for Latino and other ethnic populations

- Structured/focused Skill building groups
- IPS/Supported Employment Services
- Support for faith-based/spiritual practices in healing and recovery
- A Mobile Crisis Team, and 24 hour/7 day per week crisis services and support
- Primary Care services through the provision of assessment, screening and limited treatment on site and/or linkage to other primary care services
- Wellness Recovery Action Plan groups facilitated by consumer employees

BPSR Centers or Comprehensive Recovery Centers could also serve as the hubs for implementing early intervention strategies for those with psychotic disorders. There is growing evidence from work abroad that efforts to educate the public about schizophrenia and other psychotic disorders and establishing early detection teams that can provide access to comprehensive treatment can reduce the duration of untreated psychosis, improve outcomes and reduce long-term costs of care**.** (Larsen & Opjordsmoen, 1996; Larsen, et al. 2000) An interest in implementing early intervention strategies is now emerging in California.

C) Integration of Recovery Centers with Regional Health and Human Services

Another advantage of the regionally based BPSR or Comprehensive Recovery Center concept is that it provides one or more loci of treatment in each region. This makes it easier for providers to coordinate their efforts with a small number of mental health outpatient programs. The alternative is to work with a large and disparate array of services with different eligibility criteria and different ways of approaching other health and human service organizations.

It is suggested that the regions develop a plan to integrate the services of the Comprehensive Recovery Centers with the following regionally based services:

- Psychiatric Hospitals and Emergency Services
- Residential Treatment Programs
- Board and Care Homes (Residential Care Facilities)
- Clubhouses
- Primary Care Providers
- Homeless Programs
- Other Health and Social Services

This integration of services could include outstationing mental health clinicians at non-mental health service providers (e.g. homeless centers, primary care settings). These outstationed clinicians would identify clients with mental health needs and provide consultation so that providers can better manage clients with mental illnesses. Outstationing mental health staff enhances a non-mental health program's ability to manage the needs of mental health clients without having to link them to public mental health services.

It is also suggested that the region work to obtain funding for the following evidence based programming:

- Consumer Run alternative programming
- Supported housing services
- Mental Health Courts
- Early intervention programming for psychotic disorders
- Supported Housing
- Supported Employment and Education Services

IV. ASSESSMENT OF CASE MANAGEMENT SERVICES AND THE SYSTEM OF CARE

The following assessment describes findings about the San Diego County adult and older adult case management services and the system of care in which they serve clients. The findings in this assessment focus on both case management services and the system of care in which they operate. The issues described in these findings include the most significant topics that surfaced in focus group meetings and the consultants' review of documents and reports.

It is necessary to acknowledge at the outset that some of these findings are based on a "snapshot" view of this system of care and not an in-depth analysis of the functioning of its programs or this service system. These findings report what is considered to be important information. However, some of the concerns raised are based on limited information and may not be fully comprehensive, fully representative of the situation, or widespread in scope.

A) Findings on Case Management Services

This section on findings is presented in two themes: Description of San Diego's Case Management Programs; and Current State of the Case Management System. The "Description of Case Management Programs" section presents a profile of county and contract services for which current documents and reports were reviewed. The "current state of the case management system" section identifies significant issues that arose during stakeholder interviews and focus groups.

Description of Case Management Programs

This section summarizes the case management programs reviewed in this report. As of January 2002, the county administers county and contract programs separately. This description mirrors that choice and presents profiles of case management programs according to administrative auspice.

During stakeholder interviews with the County Case Management Chief and Contract Case Management Coordinator, it was reported that system capacity for county-operated and contract-operated case management allowed for approximately 3900 (duplicated) clients to be served throughout FY 02-03; this total includes all active and all discharged clients as well as a repeated count of clients who were served by more than one case management program (such as those clients referred by the Telecare Transition Team to another case management provider), and therefore is approximately 1,100 higher than the amount of clients served at any one point in time. As of March 31, 2003, approximately 2800 unduplicated clients were actively using case management services. Of these, 1033 clients are on LPS Conservatorship (approximately 350

clients are in locked long-term care facilities and the rest of these clients live in the community. All case management programs, except Project Payee, serve as the case management representative of the public conservator.

Utilization review of county-operated and contract-operated case management services, and access to services are coordinated via the Case Management Utilization Management Committee. This committee meets twice a month and is co-chaired by the staff in charge of county-operated and contract-operated case management services. At the present time, the emphasis of the first meeting is case review and program updates, and the emphasis of the second meeting is improvement of administrative procedures and policies.

County-Operated Case Management Programs

- 2002-2003 Budget: Case Management $4,265,412
  Conservatorship $1,737,289
  Total *$6,002,701*

Data describing County-Operated Case management programs can be found below.

Chart I: County-Operated Case Management Programs – Cases and Total Budget

County Program	Open Cases	Closed Cases	Total # Cases YTD (3/31/03)	Budget: (2002-03)	Budget: (.75/yr)
Central/N Central	892	282	1174	$2,758,085.95	$2,068,564.47
East	330	153	483	$769,698.41	$577,273.80
North Coastal	62	28	90	$160,353.83	$120,265.38
North Inland	30	16	46	$96,212.30	$72,159.23
Intensive CM	26	8	34	$192,424.60	$144,318.45
YASHI	20	9	29	$288,636.90	$216,477.68
TOTAL	**1360**	**496**	**1856**	**$4,265,412.00**	**$3,199,059.00**
Conservatorship				**$1,737,289.00**	

The county-operated Case Management program is administered by the Chief of Case Management who, in a dual role, serves as the Conservator for the County of San Diego. The County case management program is centrally administered and delivers its services in the regions via regional teams and a set of specialized teams. It has served over 1800 clients between July 1 and March 31, 2003. The case management administration offices are located in the Central region, with an affiliated office in East Region. Regionally focused teams serve clients in all regions except in the South Region. Specialized case management teams include the Young Adult Supported Housing Initiative (YASHI), which serves approximately 30 clients/year, and intensive case management, which serves approximately 35 clients/year countywide. Intensive case management

(as of July 1, 2003) and YASHI have 24/7 capability for emergent needs; service hours for the other programs are Monday through Friday, 8 a.m. to 5 p.m.

In April 1998, seven case managers were transferred from county-operated case management to county outpatient clinics to work in a multidisciplinary team model. This experience was reported by Case Management Administrative staff as having mixed results and eventually the case managers were absorbed into the workflow and role of office-based clinicians with limited case management activity.

Contract-Operated Case Management Programs

Contract-Operated Case Management is centrally administered by one program coordinator located in the System of Care Division of AMHS. This program administrator works closely with the AMHS regional coordinators. Contract-operated case management programs provide traditional case management and specialized case management services. Traditional case management services are delivered by one contractor. Specialized case management programs are delivered in the areas of dual diagnosis, transitional services, assertive community treatment, older adult services, transitional youth services, and representative payee services.

Data about contract-operated case management programs, target populations, budgets and open/closed cases are found in the chart and text below:

Chart II: Contract-Operated Case Management Programs – Cases and Total Budget

Contract Program	Open Cases	Closed Cases	Total # Cases YTD (3/31/03)	Budget: (2002-03)	Budget: (.75/yr)
APS Inc. - APS	624	139	763	$831,775.00	$623,831.25
MHS Inc –CM North	193	79	272	$540,625.00	$405,468.75
MHS Inc CM South	179	35	214	$442,330.00	$331,747.50
MHS Inc DDx	78	31	109	$543,986.00	$407,989.50
NAMI Proj Payee	101	8	109	$63,536.00	$47,652.00
Telecare Corp ACT	98	6	104	$1,046,068.00	$784,551.00
Telecare Corp Access (ACT)	91	2	93	$1,005,338.00	$754,003.50
Telecare Corp Access (Trans. Team)	59	367	426	$517,902.00	$388,426.50
Totals	**1423**	**667**	**2,090**	**$4,991,560.00**	**$3,743,670.00**

Program summaries of traditional, transitional and specialized case management programs that have been developed by AMHS and reviewed by the consultants are found below.

Traditional Case Management Programs

- *Mental Health Systems Inc. Case Management*
  2002-2003 Budget $982,955

Mental Health Systems Inc. provides traditional case management services in North and South Regions. Per the contract, the North Region carries an average of 235 clients resulting in 361 unduplicated clients during the year. Per the contract, the South Region carries an average caseload of 200 clients resulting in 308 unduplicated clients during each fiscal year. The target population is all adults, aged 18-55 years who have been admitted to local acute or State psychiatric hospitals two or more times within the past twelve months and requiring fourteen or more days of treatment on each occasion; have had a continuous mental disorder for the previous five years; or who can not use mental health services, and whose impairment interferes with independent living in the community. Service hours are Monday through Friday from 8:30am through 4:30pm.

Transitional Case Management Program

- *Telecare Managed Care Transition Team*
  2002-2003 Budget $507,747

Telecare manages one countywide short-term transition team for Medi-Cal-eligible adults aged 18 and over who are considered to be the highest risk clients with a history of multiple admissions and who have been admitted for acute psychiatric inpatient services or crisis residential services.

The goal of the "Short Term Transition Team" is to aid in the stabilization of clients after an acute hospitalization or admission a crisis residential facility; to facilitate a smooth transition to community resources; to promote short term case management services including client transportation and maintenance; and to prevent unnecessary rehospitalization or readmission to crisis residential facilities. Approximately 400 people each year receive Transitional Team services. Core service hours are Monday through Friday from 8 a.m. to 5 p.m.

Specialized Case Management Services

- *Mental Health Systems Inc. Case Management*
  2002-2003 Budget $543,985

This service provides a countywide dual diagnosis case management program. First priority is given to clients receiving mental health services. MHS Inc. is contracted to provide a variety of modalities to address the

specific needs of the population, including groups, education, and outreach. Groups and outreach are provided at a variety of locations including board and care homes, independent/sober living homes and clubhouses. The direct service staff includes peer case aides. The program serves from 75-90 clients, and the case management staff/client ratio is approximately 1:12. The contract lists as an outcome the use of an "assertive case management treatment approach" to provide integrated continuity of care within the mental health and substance abuse service systems. Service hours are Monday through Friday, 8:30 a.m. to 4:30 p.m.

- *Telecare San Diego ACT and ACCESS Team*
  2002-2003 Budget: $1,046,068 (ACT Team)
  $1,015,494 (ACCESS Team)

Telecare operates two countywide Assertive Community Treatment Teams. The first Assertive Community Treatment team (known as Telecare San Diego ACT) also offers a drop-in center. The client staff ratio for this team is 1:10, and they serve 100 clients. Business hours are five days a week, from 8am-5pm, with a 24/7 capability for emergent needs. The target population is adults with episodic psychiatric illness of long duration and a history of extended stays in locked, long-term facilities, or numerous and extended stays in acute care settings. Admission priority is given to individuals from the San Diego contracted long-term facilities; the San Diego psychiatric hospital; and the San Diego Mental Health Services System.

Services provided include: intensive case management services, crisis intervention, medication support, mental health; transportation services as necessary to support the clients treatment objectives; substitute payee services; develop an individual service plan; monitor patient's progress while in an acute setting; assist client in accessing other treatment services; including emergency shelter beds; case management contact as often as necessary to prevent unnecessary hospitalization; and maintain a set of roles, responsibilities and services for clients who are LPS conservatees. The drop-in center includes structured and unstructured activities. Structured activities include socialization, vocational or educational services conducted by staff or peer-run activities conducted by clients or guests. Unstructured activities are described as socialization activities provided for clients.

The second Telecare ACT is known as the ACCESS Team. The goal of the ACCESS Team is to provide intensive case management services to the 100 highest users of Medi-Cal services in order to reduce hospitalization costs. Services include case management, medication monitoring, client transportation, and representative payee/fiscal

management. The caseload is 100 clients and the average staff client ratio is 1:10. The PACT/ACT team uses a PACT/ACT multidisciplinary approach. Hours are the same as those of the ACT Team.

- *Adult Protective Services, Inc.*
  2002-2003 Budget - $831,775

Adult Protective Services, Inc. is contracted to provide case management services to adults 55 years and older who have been admitted to the local acute or state psychiatric hospitals two or more times within the past twelve months, or who have diagnosed long-term major mental illness. Target population criteria also include being incapable of using mental health resources interfering with the ability to live independently in the community, or requiring placement in a SNF or ICF as a result of the mental condition. Service hours are Monday through Friday, 8:30 a.m. to 5 p.m.

- *Project Payee- San Diego NAMI*
  2002-2003 Annual Budget: $63,536

Project Payee provides representative payee services to individuals who are over 18, have a diagnosed major mental illness and who have been referred by San Diego County Case Management programs. The program serves a minimum of 100 clients. Service hours are Monday through Friday, 9 a.m. to 5 p.m.

Current State of the Case Management System

Overview of Case Management System Development

The current state of Case Management services in San Diego County is not atypical of public urban mental health systems in California and throughout the country. Case management is used as the primary and central programmatic element for providing and coordinating care and treatment for a population of high need seriously mentally ill individuals.

There are a variety of differing case management services that have been established with differing levels of intensity of service and/or focusing on particular populations to respond to different levels of need. Among the developments in case management programming is the implementation of ACT teams that appear to incorporate a program model that is largely consistent with the principles and structure of the original PACT model. The county has also developed specialized case management programs that focus on the needs of older adults, and dual diagnosis clients (with co-occurring mental health and

substance abuse disorders). In addition, a transitional case management team has been established by diverting funds from other resources to provide short-term linkage services with the intent of reducing recidivism for clients being discharged from acute hospitalization.

These services have been developed over time, and as a result, the county's case management services could be described as a patchwork of specialized programs to respond to different systemic needs and populations, and using different approaches and methodologies.

This patchwork is increased by the larger administrative context. As of January 2002, case management services are administered under two auspices: county-operated services and contract-operated services. Efforts to coordinate access and utilization review across the county-operated and contract services are accomplished via bimonthly meetings of the utilization management committee. However, feedback from stakeholder interviews and focus groups questioned the administration of case management under two auspices. The consultants observed that county-operated programs are traditionally organized, whereas contracted case management programs are specialized and incorporate a higher degree of flexibility and innovation, lending themselves to a higher degree of integration within the mental health system. These cultural differences, combined with a bifurcated administrative structure and different leadership styles, create a case management system that reduces opportunities for innovation and creativity, integration with the wider mental health system, rapid access to case mgt services between the two systems, parity of resources and a shared vision and understanding about state-of-the-art case management practices.

Strengths of Case Management Services

San Diego County has made significant and demonstrable efforts to further develop and enhance its case management programs. These developments clearly follow through on recommendations of the system of care planning documents, incorporate state-of-the-art technology, and are consistent with psychosocial rehabilitation concepts and principles the county has adopted.

At least in recent years, the county has furthered its system of care within the context of a clear philosophy and programmatic expectations. Unlike many other public systems, the continued development and enhancement of (or reductions in) case management services have not solely been budget driven. This is a strength, and is evidenced by implementing ACT teams that appear to be largely in fidelity to the original model, the development of specialized case management programming for older and dually diagnosed populations, the reduction in the numbers of clients conserved, and the reduction of caseload size in case management programs.

Criteria for admission to case management programs are consistent with other public mental health systems and focus on high need clients, as evidenced by priority status for those requiring LPS conservatorship, utilizing high levels of acute services, and/or demonstrating high costs to the mental health system. The county has reduced caseload sizes in order to be able to provide more intensive case management services for a high need target population. Caseloads have been reduced by both reducing the number of clients served in some case management programs, and by developing other case management teams that, by design, require low client to staff ratios. There has also been a dramatic reduction of the number of clients on LPS conservatorship.

Case management services in San Diego incorporate highly qualified staff, and appear to include a large percentage of clinically prepared professionals. In focus group meetings this staff appeared to be committed and passionate about delivering quality care to their clients. In these discussions they also demonstrated an understanding of and support for implementing services that were consistent with a PSR philosophy of care. Some clients and family members in focus group meetings reported a high degree of satisfaction with the services they received from case managers.

These structural developments in case management and the focus group reports indicate that the San Diego County administration is taking advantage of opportunities to move its case management services in a direction that is consistent with the expectations of its planning documents, and in keeping with its intention to implement PSR approaches.

Uneven Implementation of and Access to Case Management Services

On the other hand, there appears to be an uneven level of service provided throughout the case management system. The dissimilarities in service delivery appear to go beyond the intended differences in levels of intensity for the programs. For example, it appears that while staff in all programs report support for PSR concepts, there is evidence that some case management programs provide services that are more consistent with these concepts than others. In addition the staff in some programs appear to be enthusiastic about their roles, and other expressed frustration about not being able to implement them appropriately. There also appear to be differences in how consumers experience these services. A consistent theme in the focus groups was that consumers in some case management programs experienced their case managers as authoritarian, and that the case managers did not adequately understand or support their stated goals and wishes. Others stated that their case managers were wholly supportive of their personal plans and hopes. Not surprisingly, case managers with smaller caseloads were perceived to be the most responsive.

The county-operated traditional Case Management Team primarily offers monitoring functions for clients who are often on conservatorship, and reside either in IMDs or Residential Care Facilities. While monitoring is an important and essential component of case management that is associated with positive outcomes in terms of reduced hospitalization rates, it is insufficient for supporting clients in full reintegration into community life and supporting their goals. It was also reported that at this time this program has unfilled consumer roles (despite a long history of hiring consumers and recent efforts to recruit people for these positions), and that the liaison functions with other providers need to be increased.

There is also a question about the outcomes associated with the specialized contract programs. While it was reported that the short-term case management program is successful in linking clients being discharged from acute hospitals to housing, linking these clients to ongoing treatment services has been a challenge. Like all programs in the system, difficulties were also reported with working with psychiatric hospitals. For this program this relationship is critical because clients must be engaged within a relatively short time frame while they are still in the acute setting. It was also suggested that this service also be available to clients being discharged from the START as per the expectation in the program's contract. Limited data was available at the time of this writing on the effectiveness of this program in reducing recidivism to acute hospitalization.

There appears to be uneven access to case management services in the county. This is primarily due to a lack of capacity to provide case management services to all clients who could benefit from it. It was also noted that there are differing level of capacity and availability of case management services in the various regions of the county. In terms of case management availability, it was reported that access has improved as a result of establishing the case management utilization management committee. On the other hand, providers from an array of different programs indicated that they could not link their clients to case management services. No consumers in the focus group meetings knew how they might get case management services, except for getting themselves repeatedly hospitalized. It was also reported that individuals without funding and an address are not eligible for case management services, even though such homeless mentally ill clients may be at considerable risk for rehospitalization. The case managers who held this understanding may not have been aware of the county's policy of referring indigent homeless individuals with severe mental illness to the County Homeless Team that is affiliated with the county outpatient clinics.

Programmatic Limitations

There are some notable concerns about the case management system overall in San Diego County. Of significant concern for some case management programs is the lack of integration with psychiatrists and medication services. Programs

without a psychiatrist on staff often rely on Fee-for-Service psychiatrists who are not an integral part of the program. There were numerous reports by case managers of difficulties in contacting and communicating with psychiatrists both on routine issues and in times of crisis. In addition to limited access to these psychiatrists, there are often differences of approach and philosophy between the case manager and the treating physician that contributes to significant discontinuities in treatment.

Other issues include little to no support for clients who want to work. Most case managers stated that virtually none of their clients were employed. Many reported that their clients did not have access to the one mental health vocational program in the county. At the same time a large majority of consumers in the focus group meetings indicated that they wanted a job but were not employed and did not get assistance and support from the mental health system to support this goal. The exceptions were the consumer staff who work in the Clubhouses, who reported good support.

Another issue is that very few case managers work with clients' families. Most case managers indicated that they had little to no involvement with family members. It was repeatedly stated that most families are "burned out" on their mentally ill family members and would not be interested in a better relationship and/or cannot be located. The focus groups provided no evidence that case management programs are providing formal psychoeducational programming for clients' families, although some case managers refer families to NAMI.

There seems to be some systematic exclusion of clients with families who are actively involved with the clients in case management services. For example, clients who have a family member as their conservator are excluded from access to case management services by policy. It was also suggested that clients who live with their families have more limited access to case management services than those living in other settings. The exception is case managers (and outpatient staff who function as case managers) who work with Latino clients. These case managers indicate that they routinely work with the families of their clients, many of who live in the family home.

There does not seem to be any clearly culturally focused case management services in the county. There is a strong effort to hire bicultural/bilingual staff who represent the ethnic diversity of the county in addition to ongoing training on cultural competence throughout the system of care. However, 27% of the county is from a Latino background and there appears to be no case management service that is culturally focused, specifically, and at all levels, on serving the distinct needs of Latino populations. There are smaller populations of African American, Asian, Chaldean, and Russian populations in the county. Beyond hiring staff representing the backgrounds of these populations and the availability of translators, there is no evidence of culturally focused programming in case management services for these groups. The Union of Pan Asian Communities

(UPAC) does appear to provide culturally focused outpatient treatment to clients from multiple Asian backgrounds.

There are no apparent performance standards available or used by which to measure the effectiveness of case management services, or to compare outcomes throughout the service system.

Internal Case Management Issues

There were a number of issues raised about the ability for case managers to fully implement their roles and particularly to provide services that are consistent with the PSR philosophy. While all of the issues described below were stated repeatedly, it is expected that some of these issues may be of more significance in some case management programs than in others.

The single largest complaint of case managers had to do with the amount of paperwork required. Documentation requirements, and particularly Medi-Cal expectations cause unnecessary burdens that limit service capacity in all systems throughout the State. Some case managers noted correctly that Medi-Cal system is based on a model and has expectations that are contradictory to PSR concepts.

Even so, there is evidence that the paperwork requirements are more onerous in San Diego County than necessary. For example, it was reported that case managers in some programs spend a majority of their work time, and in some cases up to 70% of the time, on paperwork functions. It was expressed that much of the paperwork is redundant and unnecessary. It was also suggested that new paperwork requirements are routinely added with no consideration of ways to coordinate or consolidate these expectations with paperwork expectations that are already in place. The case management line staff believe that, if allowed, they could easily recommend ways to reduce the paperwork expectations and still provide all necessary information. Many expressed eagerness to do so.

It was also expressed that the role of conservator and representative payee influences the delivery of case management services in ways that are inconsistent with PSR concepts. By definition the role of conservator and representative payee represent imposed authority over clients and this can inhibit establishing relationships that support client self-direction and collaboration.

San Diego County has implemented successful efforts to reduce the number of LPS conservatees. Since the System Redesign Plan was published the number of conservatees has dropped from nearly 1600 to 1033 in March of 2003. Of those currently conserved, almost 60% are placed in SNF/ICFs or locked settings (including out-of-county placements) and slightly over 40% live in the community, primarily in Residential Care Facilities. Case managers raised questions about

some of the approximately 400 individuals who remain on LPS conservatorship while remaining in stable living situations in the community. There are apparently no clear criteria about what defines grave disability and acceptance of treatment voluntarily, and, therefore, the criteria for continued conservatorship for these clients. It was also stated that conservatorships are often dropped for the clients who need it most. There appears to be no formal approach or expectation to support clients who want to be independent and to get off of conservatorship.

While concern was expressed about the authoritarian role of case managers as representative payees, the major concern was the extraordinary paperwork burden imposed by this role. Some case managers reported that the paperwork associated with this role was the single most time-consuming function of their jobs, and one in which some devoted more hours to than working directly with their clients. Case managers also indicated that the representative payee role should be used as a teaching tool that ultimately supports client independence, but that it was not used this way often enough. Case managers also indicated that authorizing disbursements for clients who required a representative payee could be an appropriate role for a case manager, they also believed that they had too much responsibility for implementing the logistics of this system (i.e., paperwork requirements) that could be managed more efficiently by eligibility and clerical personnel.

Some case managers were vehement in their concern that their recommendations were not honored in placement authorizations, often to the detriment of their clients. These issues related to having their clinical judgment overridden by people who they believe do not have the clinical experience to make these decisions. They described situations in which clients experienced significant bad outcomes as a result, and the case manager was left working with the client in a situation that they knew was inadequate and potentially harmful. It is alarming that case managers described some very high-need clients as being “unplaceable” anywhere in the system. It was described that some clients cannot be authorized for placement in levels of care that could protect them and the community from dangerous behaviors because they are determined not to be “rehabilitatible” and/or would represent a “high liability” for the treatment setting. If correct, this represents an unacceptable situation for clients, for those responsible for caring for them, and for the community.

In the focus group meetings case managers did not express any clear client discharge criteria for their programs, except for when the client moved out of the county or died.

There appears to be a lack of or inconsistencies in the availability of the necessary tools and resources to most effectively and efficiently provide case management services. Some case managers stated that they had access to e-mail and the Internet, while others did not. While some staff had full access to cell phones through their employer some had limited access, some used their

personal cell phones to provide services, and some had no cell phone access at all. There is also no consistent availability of a petty cash fund with which clients could be provided small amounts of money as a grant or a loan to support the goals of the service plan. The county does not use a computerized charting system in any of its mental health services, and concerns were expressed about the inability to obtain useful management information from the existing billing and information system.

While San Diego County does appear to provide a significant number of training opportunities, compared with other jurisdictions, some case managers reported dissatisfaction with the training they receive. Some expressed concern that they were mandated to participate in some trainings that were too basic and not useful. The line staff indicated that they had no say in the trainings that were offered, and that there were important training topics that were not addressed by the county training programs. Focus group feedback indicated frustration that case managers could only attend trainings sponsored by the county training program. Case managers believed that a policy existed that their time could only be paid for while attending county sponsored trainings. This may be explained by the fact that county and contract programs have limited budgets for outside trainings.

Case managers stated that they are not adequately compensated for the responsibilities they assume and the level of training and skill required to provide services. Some of the county staff were concerned that their salaries were among the lowest in the state for comparable positions. The salaries described for some contract case managers do appear to be considerably lower than those paid for comparable positions in other urban counties in the State. Staff indicate that all of the issues described in this section, but particularly the low salaries, result in a very high turnover rate of staff in case management programs. They state that high staff turnover rate negatively impacts continuity of care and the overall effectiveness of case management services.

Case Management Integration with the System of Care

It was noted in the San Diego County Case Management Services Workgroup Report (May 2000) that case managers are known to be the “glue” that holds a system of care together, and integrates services on behalf of clients. Therefore, the effectiveness of case managers is greatly determined by their relationships with other providers in the mental health system, and with other community resources.

As described above, a lack of continuity of treatment in some case management programs is the lack of integration of the psychiatrist and medication services with these case management services. There is also considerable evidence of inadequate collaboration and integration of case management programs with

hospitals, residential care facilities, other mental health services, primary care services, housing resources, transportation services, and other resources that are critical to the success of community reintegration for case management clients.

It is a premise of this report that the effectiveness of case management programs is predicated on the availability and capability of community resources, as well as the degree of collaboration and coordination with these resources. As the issues within this system of services affect all programs and not only case management programs, a separate section of findings on system of care challenges and opportunities is included below.

Bifurcated Case Management Administration

The structure of the Adult and Older Mental Health Services Division has a bifurcated administrative structure for case management services. That is, the country-operated case management services have one reporting line through the administrative structure, while the contracted case management services have another. This complicates the administration's ability to develop a consistent and coherent approach, philosophy and practice for case management services design and delivery.

Expressed Need for More Case Management Services

The most consistent finding about case management programming, at all levels throughout the county, is the belief that more case management services are needed. This was expressed as a need to both increase the capacity of case management programming to increase the number of clients who can be served, as well as to further enhance the services that are provided in existing case management programs.

Despite this unanimity on the need for additional case management resources, there were considerable differences as to how to expand and enhance the case management system. Some supported regionalizing these services while others thought centralization of case management would be more efficient. Similarly, some individuals thought that contracted case management should be provided by a single contractor, while others appreciated the diversity and competition that multiple contractors offer. There were also diverse opinions about the need for creating more specialty case management programs versus preparing staff within general case management programs to meet special needs.

B) System of Care Challenges and Opportunities

A number of system of care challenges and opportunities were reported throughout this planning process. These issues directly affect the ability of the entire system of care, including case management services, to provide effective

and efficient care and treatment. These range from the improved provision of a range of services to more fully incorporating consumer leadership into the system of care.

Psychiatric Hospital and Emergency Services

With the development of comprehensive community based mental health service systems, the locus of care and treatment for seriously mentally ill individuals has moved from hospital settings to community settings. This is evidenced by the single point of accountability for treatment being located primarily in case management and outpatient services. Nevertheless, the nature of serious mental illnesses is that many individuals experience relapses that result in periods of time in hospital settings.

One goal of case management and other community services is to reduce utilization of psychiatric hospital services both by reducing the number of admissions and by reducing the length of stay when hospitalization is necessary. This requires close collaboration between hospitals and community services as well as clarity and respect for the roles of providers in both inpatient and outpatient services.

Providers throughout the San Diego County system of care, at all levels and including both inpatient staff and outpatient providers, describe multiple issues that demonstrate poor integration and collaboration between acute and community services. A sampling of the issues described begin with the experience of case managers and outpatient therapists that it is labor intensive to admit clients, and that these efforts are frequently for naught because their judgments about the need for hospitalization are often not accepted. One example is that hospitals have denied admission because the client has been abusing drugs and/or alcohol and is determined to have a “primary” substance abuse disorder. This happens when there is ample documentation that the client is also diagnosed with a serious mental illness.

It was reported from both hospital and community providers that there is poor communication between them. Inpatient providers indicate that it is difficult to know when a client has a case manager and who that person is. In addition, identified case managers are not often available when needed. Outpatient providers report frequently not receiving the mandated “Morning Reports” in a timely manner and a difficulty finding appropriate and responsive inpatient staff. When community providers admit a client, they report a loss of control of treatment in terms of medication changes, and sometimes even in terms of discharge decisions. This is, in part, because the hospitals also use Fee-For-Service physicians and there are communication and treatment discontinuities within the hospital setting between the physicians and the hospital based nursing and social work staff. Community providers also report clients being discharged without notice, without appropriate discharge plans in place, and without

collaboration with case managers and other services. Acute service providers describe discharge decisions for clients that do not have a case manager as a "random process" because they usually take the first available bed without knowing the quality of the setting or whether it is the most appropriate to meet the client's particular need.

Related issues include the report of ACT teams that they have attempted to obtain admitting privileges for their psychiatrists, which would resolve many of the issues described above, but these privileges have not been approved. The START acute residential programs also indicate that their clients are not eligible for Transitional Case Management programs even though these clients are often as acutely ill and require the same level support after discharge as patients being released from hospitals. While all of the issues described here result in a great deal of discontinuity that limits both the effectiveness and efficiency of treatment the system of care, they also represent commonly found challenges in most public mental health systems throughout the world.

Housing, Residential Care, and Independent Living Facilities

Probably the greatest unmet need for individuals with serious mental illnesses in urban counties throughout California is the lack of safe, decent, and affordable housing. In San Diego County, there are few independent or supported housing options that are within the means of individuals who live on SSI or other public entitlements. It appears the situation in the county is getting worse with loss of access to inexpensive single room occupancy hotels and increasingly limited access to Federally supported Section 8 vouchers. With increasing housing costs it is also difficult for individuals who do receive these vouchers to find housing that falls within the Federal subsidy limits.

Case managers report relying on Residential Care Homes and Independent Living Facilities as the primary housing options for their clients. Residential Care Homes are licensed to provide care and supervision to individuals who require this level of care. Independent Living Facilities appear to be unlicensed boarding houses that provide a room and meals to mentally ill individuals but do not supervise medication adherence.

Residential Care Homes are described in mixed terms. On the one hand they are heavily relied on as a placement resource. It is also noted that some of the administrators run quality facilities and collaborate effectively with case managers and other providers. Many of these facilities have arrangements with psychiatrists that can prescribe and adjust medications. Some are also reported to provide access to primary medical and dental care.

On the other hand, it is also suggested that there are significant challenges with many of these facilities. This includes descriptions of poor cleanliness, client complaints about the food, administrators and staff with limited knowledge of

mental illness and its treatment, questionable staff/client boundaries, lack of English-speaking staff during evening and weekend hours, and limited or no programming in the facilities.

There are 125 mentally disabled (MD) residential care facilities, eleven of which receive supplemental funding from the county. While Residential Care is a major housing resource and there are a number of concerns about the appropriateness of care, there is no systematic effort to work with the facilities and to use this resource most effectively or to improve conditions in the facilities. There are no forums to dialogue with Residential Care administrators to understand their needs and to better support them to improve their facilities. There is also no central registry of vacancies or process to coordinate placements into Residential Care to respond to both client needs and wishes. The county provides no training for the administrators and there is no evidence of programming to clients that is provided in the homes (beyond the augmented services program). Clients who lived in Residential Care Homes indicated that they did not have support from their case managers when they expressed the wish to move from Residential Care to independent living.

It was also suggested that the Independent Living facilities vary in quality, and that there is no formal or coordinated effort to understand the needs of the operators, or improve, or further develop this essential housing option.

Outpatient Services

There are a number of county operated and contracted mental health outpatient clinics that are located in all of the mental health service regions in the county. Outpatient clinicians are the designated care coordinators for their clients, and can bill for providing case management brokerage services. Some of these clinicians provide what could be described as comprehensive case management services. These clinicians also have access to integrated psychiatric services within their clinics. Outpatient clinicians are able to provide services in community settings, but they infrequently do. It was reported that many seriously mentally ill clients receive medication-only services from outpatient clinics.

It was described that some case manager positions were previously assigned to provide regionally based case management services. However, these staff were assigned to other clinic functions and were not available to take case management referrals. It was also noted that there can be confusion as to who has ultimate responsibility for care when a client is assigned both a care coordinator and a case manager from different programs, even though this is defined in policy. Many outpatient clinic staff indicated a willingness to expand their services to provide comprehensive case management programming if they had they resources to do so.

Transportation Needs

A number of transportation issues were reported for case managers and other providers. Included among these is difficulty obtaining transportation for hospitalizations when a client meets criteria for involuntary treatment. It was reported that the PERT team can be helpful but it is not always available.

Many non-mental health services are located in regions outside of the one where the client's outpatient facility or home is located. Most regional focus groups reported a need for vans and drivers to take clients to these appointments. This was reported as a critical problem in the larger geographic regions. In addition, the safety of the bus system was questioned; female clients have been victimized while waiting for buses.

Clubhouses

The development of clubhouses in San Diego County provides a service that is used by a broad array of individuals with serious mental illnesses. These community based centers are well attended, appreciated by the clients, and provide a critical stronghold for client-to-client efforts that support recovery. Clients suggested that the function of the clubhouses should be expanded. They suggested that the clubhouses might be used to "grow" peer support programs (i.e. outreach services to the board and care homes; peer counseling training programs). Clients at one clubhouse have received training through the NAMI Peer-to-Peer program and wanted to enroll more clubhouse members in this peer support training.

Many of the clients who come to the clubhouses reported that they found the inspiration they needed to live and recover through connections made at these programs. Clubhouse based focus groups included many clients who felt they were far enough along in their recovery to be ready for paid or volunteer work. Most focus groups included clients who wanted to be of service to their peers. It was clear that the clubhouses can be used to further develop and train the client leadership base; several of the current client leadership work in and around the clubhouse system.

The clubhouses also represent one modality in the county that consistently hires mental health consumers as direct service providers and program leaders. These programs do not meet the standards of the Fountain House model and do not provide much focus on supporting clients to obtain competitive employment.

Client Leadership

System of care evolution towards a PSR orientation cannot be adequately motivated or actualized without the equal collaboration of client leadership. The group of clients who meet monthly with the mental health director possess skills

and a collaborative ethos that is unique in the state. A clear system of care opportunity is to acknowledge and actively incorporate client leadership into the major committees of AMHS.

A client leadership infrastructure could easily be nurtured in the clubhouse system. Several clients were identified in each clubhouse visited during focus group interviews who were interested in becoming allies with county-initiated PSR efforts. These clients were interested in taking on peer support roles within the clubhouses and with the board and care facilities. Other clients who had advanced degrees and possessed outgoing and articulate spirits were interested in working with the clubhouse and central administration to further develop consumer managed programs and/or work with a wellness/recovery task force. Other clients were interested in advising the county on rethinking case management roles and responsibilities.

The skills required to be successful at committee work are not common in the general population. Integrating clients (or anyone else) into consultative roles requires leadership training. The California Network of Mental Health Clients has SAMSHA funded client leadership training courses that San Diego consumers could attend. The Alameda County BestNOW! Peer Counseling training curriculum also incorporates a leadership-training component.

An important corollary to this effort is the availability of stipends to reimburse for transportation, per diem and time. Clients (and family members) are often the only individuals at meetings who are not paid for their time. It is important to develop a budget to reimburse clients for their expertise and time.

Consumer Employment

One of the most effective ways to increase everyone's confidence that clients can "recover" is the presence of consumers in the mental health system who have achieved life beyond "maintenance and stabilization." Clients who are receiving services (and their providers) need to see and talk with consumers who work and live independently. Consumers who are employed as peer counselors, analysts, receptionists, and managers make the story of how the move from being a mental health client to rejoining a life tangible. Consumer employment is a critical part of any strategy to incorporate PSR into a system of care. This is supported by the experience of San Diego's successful AB2034 program, which was designed on the premise that peer support is a critical catalyst in the recovery process.

Achieving successful consumer employment on case management teams will entail necessary cultural change; it is often hard for co-workers to accept a consumer as a member of a treatment team. Many traditional questions about roles and boundaries have to be addressed. And, if one is the first consumer hired on a treatment team, it is difficult to be on the vanguard. Successful

consumer employment requires a systematic effort to establish a small number of programs that work, and then slowly replicate those models throughout the mental health system. Some case management programs have instituted some consumer positions, and report interest in continuing this. The recommendations section of this report includes a section on making consumer employment the norm in all mental health programs.

Political Culture and Funding Issues

In addition to the need for more case management services, the only other issue for which there was unanimity was the need for additional funding for mental health and other health and human services needed by individuals who struggle with serious mental illnesses in San Diego County.

The political culture of any county has a significant bearing on the development of public health services, including mental health services. It was reported that the political culture in San Diego is conservative regarding the development of public health and human services. On the other hand, the political culture does support efforts that promote self-sufficiency and reduced reliance on public services. It also supports efforts to make government services more efficient and effective.

V. RECOMMENDATIONS FOR A CASE MANAGEMENT STRATEGIC PLAN

Overview

The following recommendations provide a broad direction and specific steps to further develop case management and other services within San Diego County Adult and Older Mental Health Services. They are based on the assessment and findings described above and provide specific recommendations for enhancing these services and the system of care in which they work. These recommendations are based on evidence-based practices that are consistent with the psychosocial rehabilitation (PSR) approach that has been adopted by the county. These recommendations are designed to move the county towards becoming a state-of-the-art community based public mental health system.

As discussed in all of the documents related to this process and within this report, case management is considered to be the central focus of treatment for a client population that is the primary responsibility of public mental health services systems. Yet, case management client outcomes depend on much more than a case manager. They are also dependent on the effectiveness of and collaboration with the entire mental health system, other health and human services, and an array of formal and natural community supports. As a result, the recommendations are based on a definition of case management as comprehensive treatment, and suggest that all programs in the mental health system share the responsibility for implementing services within a comprehensive treatment model of care.

The focus of this report is to suggest strategies and make specific recommendations to further develop and enhance mental health case management services for adults and older adults in San Diego County. The approach for this plan is to look at all case management services and the overall system of care in which they operate. The following eight sets of recommendations are intended to support the development of a Case Management Strategic Plan:

I. Consensus Development – Vision for an Integrated Regionalized Mental Health System
II. Establish a Case Management Definition
III. Reprocure Contracted Case Management Services
IV. Prepare to Restructure the County Case Management Program
V. Develop Low-Intensity Case Management Capacity in Outpatient Services
VI. Improve the Effectiveness and Efficiency of Case Management Programs
VII. Improve the Integration of Case Management Services with the Mental Health Service System
VIII. Strengthen the System of Care

Set 1: Consensus Development – Vision for an Integrated Regionalized Mental Health System

San Diego Adult/Older Adult Mental Health Services would benefit from a process that articulates and develops consensus for a vision of an integrated regionalized mental health system, and for the role of case management within the regionalized services. The size of the county, in terms of demographics and geography, and its ethnic diversity, suggest that a regionalized system is the most appropriate for San Diego County.

A vision for an integrated regionally based mental health system is described in this plan. The central concept is the development of Biopsychosocial (BPSR) Centers or Comprehensive Recovery Centers that are the clinical home for seriously mentally ill clients in the region. These centers would provide an array of outpatient services that include a range of intensity of case management (comprehensive treatment) services that are integrated with a variety of evidence-based interventions that have been demonstrated to improve outcomes for populations with seriously mental illnesses. Implementing this model would provide San Diego County a role in defining and setting the standard for an emerging concept in state-of-the-art mental health system development.

The consultants acknowledge that some regions in the county have small target client populations and can provide only limited services. Therefore, it would make sense for these regions to provide only core services (i.e., the central elements of a BPSR Center or Comprehensive Recovery Center, a Clubhouse, and others) and share additional program elements and system of care development responsibilities with a neighboring region.

Recommendation

1.1 Mental Health Administration to convene a stakeholder group to develop a consensus that supports a regionalized system of care. The Regional Providers meeting is recommended as the organizational unit to sponsor the discussion of this vision. Stakeholders invited to the discussion might include clients, family members, contract and county providers, and representatives from affiliated county services (transportation, housing, social services and public health). The outcome of this stakeholder process would be to build consensus for and adopt an agreed upon vision for an integrated regionalized mental health services. This vision could be based on that suggested in this report and incorporate the development of BPSR Centers or Comprehensive Outpatient Recovery Centers. In any case it is suggested that a plan for developing a regionalized system is necessary so that a cohesive and coherent plan to regionalize case management services can be established and implemented.

Set 2: Establish a Case Management Definition

This report suggests that case management services be enhanced and expanded in the county through a multi-faceted strategy that involves, 1) reprocuring contracted case management programs, 2) restructuring the county operated case management service, and 3) establishing low-intensity case management programming in outpatient clinics. Such a case management strategic planning effort needs a common understanding of the term "case management" that will provide a foundation for the role of providers who offer comprehensive treatment services to clients. A wide array of providers in the county will be providing case management services, and other programs such as hospitals, clubhouses, residential providers will need to have a clear understanding of what can be expected in their working relationships with case managers. All of this makes it critical to develop a common understanding of the case management role.

The existing case management programs in San Diego County appear to work from different conceptualizations of case management services. While case managers in all programs espouse support for the PSR model, only some described that what they do to include comprehensively supporting clients' needs and supporting clients in defining and pursuing their personal goals. On the other hand, some case managers and administrators indicated that the purpose of case management is to keep mental health clients out of the hospital.

While these might sound like merely differences in emphasis, how case managers define their role can have a profound effect on how they define their work and deliver services. For example, it is suggested that the purpose of case management is not at all to keep people out of the hospital. Rather it is to provide the services, treatments, and support to meet the clients' needs in ways they can accept and use. Appropriately responding to client needs has been repeatedly demonstrated to reduce both the number of admissions to hospitals and the length of stay. But the difference is that this is the general result of the work and not the purpose. It is equally necessary to understand that many clients continue to need hospitalization and, when this is so, it is the role of the case manager to see that it is available for either brief or long periods of time, as best serves the client.

Recommendation

2.1 Adopt a countywide definition for case management services. This definition would apply to all clients who are assigned to a case manager or a care coordinator in any program in the San Diego County Mental Health System. A definition of case management is provided below. The county may want to accept this definition, modify it, or develop another:

Case Management provides comprehensive treatment through a process that actively engages clients, develops a comprehensive assessment, and implements a treatment plan that focuses wellness and recovery, by supporting clients in defining and pursuing their personal goals.

Case management is implemented by assigning an individual case manager, clinician, or a team of staff who assume the single point of accountability role that includes responsibility for developing, implementing, and monitoring the outcomes of a comprehensive treatment plan for as long as services are needed.

Each comprehensive treatment plan is developed and implemented in collaboration and partnership with the client, and if the client agrees, with family and other natural support system members. While comprehensive treatment makes available any service or support that could meet a client's needs, the case manager only provides services that cannot or will not be provided by others including what clients can do for themselves

Set III: Reprocure Contracted Case Management Services

An expectation of this planning process is for recommendations to be made with regards to the reprocurement of the county's mental health case management services. Reprocurement of contracted programs is an expected aspect of the mental health system redesign plan initiated in 1999.

The currently contracted case management programs in the county are centrally administered and provide services to clients that are referred from throughout the county. The first recommendation in this report suggests that all case management services eventually be incorporated into regional service systems. It is understood that developing and implementing a vision for a fully regionalized system will take time. The question at this time is how the currently mandated reprocurement requirement can be used to enhance, and further develop case management services within the existing system of care.

The contracted case management programs in San Diego County, for the most part, represent best practices in comprehensive treatment programming. The Assertive Community Treatment team approach has been repeatedly demonstrated to be the most effective service model for very high need clients. In addition, there is evidence that specialized mental health case management programs for geriatric clients and individuals with co-occurring substance abuse disorders are effective for these populations. It is also a common practice throughout the country to establish transitional case management programs, even though the effectiveness of this model has not been demonstrated.

From the information and data provided, it appears that all of the contracted case management programs are functioning adequately within the context in which they are working. The ACT teams appear to be implemented in fidelity to the established model, and the specialized case management programs appear to provide services that are appropriate to their mandate within allotted resources and expected caseloads. In addition, these models of case management services are an appropriate design in a centrally managed system of care and when case management services are delivered countywide. This is because a larger population to draw clients from makes it possible to establish specialty programming that might not be feasible in regions with smaller numbers of clients. At this time, there is no additional funding available to expand these contracts.

Therefore, for the current reprocurement, the basic structure of these services is appropriate. When, and if, the county moves toward a fully regional system of care there could be good reason to alter the structure of these programs.

Recommendations

3.1 Incorporate recommendations designed to improve the effectiveness and efficiency of case management services (Set 6); incorporate recommendations into RFPs for the reprocurements; and reprocure contracted case management programs using the current centrally managed model and retaining specialized case management teams.

- This will require prioritizing these recommendations and determining which are most needed to respond to the current needs and issues in the county (current needs and issues are identified by the consultants in Sections IIB and IV A and B of this report). Some of these recommendations may be appropriate for all case management programs and others for only some of the case management services. For example, the performance standards that are adopted would apply to all contracts, while the recommendation to integrate psychiatrists into case management programs has already been achieved within the ACT Teams.

3.2 Complete an evaluation of transitional case management programs. Include a simple pre/post test format for clients served to determine this program's effectiveness in reducing recidivism and linkage to ongoing mental health treatment. If the outcomes are positive, continue and possibly enhance this program. If not, then reprocure this program to provide longer-term intensive case management services.

Set 4: Restructure the County Case Management Program

The existing county-operated case management services represent significant resources and expertise for enhancing comprehensive treatment delivery throughout the system of care. Integrating the current county case management staff into the existing County and contract clinics could have important benefits for the entire system. This could be a part of a longer-term initiative to integrate and regionalize case management services. Advantages of such a strategy include:

- Providing case management services in closer proximity to the clients served
- Integrating psychiatrists and case managers in the clinic program
- Providing role modeling/consultation/supervision for outpatient clinicians/supervisors/managers that are learning the case management role recommended below
- Developing a culture of comprehensive treatment within the clinics
- Preparing for the establishment of Comprehensive Outpatient Recovery Centers or another vision developed for regionalized service delivery

However, it is acknowledged that previous efforts to outstation county case management staff into outpatient services have had mixed results. It was reported that case managers were "absorbed" into other clinic functions and were not available to serve their target population as expected.

Therefore, the following recommendation, in combination with other recommendations in this report, is for the MHS Administration to consider the feasibility of integrating case management staff into outpatient clinics.

Recommendation

4.1 Convene a broad stakeholder committee to explore and consider the feasibility of integrating county case management staff into County or Contract outpatient clinics. This committee would include county administration, case management leadership, contracted case management leadership, outpatient services leadership, staff, clients, and other stakeholders. This committee would evaluate, analyze and make recommendations to the MHS Administration as to advantages and disadvantages and the feasibility of integration.

Set 5: Develop Low-Intensity Case Management Capacity in Outpatient Services

There is strong agreement that more case management services are needed to serve clients currently eligible for Adult Mental Health Services. There is also a large population of individuals with serious mental illnesses who do not have

access to case management services because they have not met threshold criteria in terms of number of hospitalizations and/or costs or other criteria indicating high need for case management. These individuals need case management services to prevent the occurrence of severe symptoms that will, paradoxically, increase impairment and eventually make them eligible for case management services.

An element of the recommended vision in this plan is to develop BPSR Centers or Comprehensive Recovery Centers in the county's regions. These Centers are envisioned as outpatient clinics that will provide a range of comprehensive treatment services of varying intensity, including case management services. These Centers may also offer (additional or alternate) services to those persons served by the fee-for-service centers.

There are a number of advantages to developing the capacity of the existing regionally based outpatient programs to provide case management services. First of all, this is one way to increase case management capability throughout the county at this time. It will also prepare the clinical staff and the leadership to provide services within a comprehensive treatment model if Comprehensive Recovery Centers are established.

Although previous efforts to incorporate case managers in outpatient clinics has resulted in these staff being "absorbed" to fulfill other clinic functions, it is believed that with strong commitment, clarity of intent and effective leadership it is possible to absorb current outpatient clinicians into case management functions. It is also currently the situation that a number of clinicians in outpatient services already provide what would be described as clinical case management services.

Recommendations

5.1 Provide low-intensity case management services in county outpatient clinics. Reinforce and expand the care coordinator role as the single point of accountability function for clients who have multiple needs but do not meet eligibility criteria for existing case management services

5.2 Provide training to outpatient clinicians and clinic leadership on case management roles

5.3 Provide individual and group supervision for clinicians who are providing case management services

5.4 Utilize existing county case management staff and supervisors to provide consultation and supervision to outpatient clinicians prior to integrating these staff into the clinic settings.

Set 6: Improve the Effectiveness and Efficiency of Case Management Services

The following recommendations are intended to improve the effectiveness and efficiency of case management services. The recommendations are based on the findings in this report, evidence based practices, and/or experience in other mental health jurisdictions. As a whole, the recommendations provide a comprehensive approach to improve client outcomes by enhancing the existing service delivery system. A number of specific recommendations are included to improve case management programs, to enhance the relationship between case managers and other providers, to further develop evidence-based programming in the county, to suggest funding and community strategies for developing the system, and to describe appropriate performance outcomes.

It would be efficient for county leadership to set up a process to evaluate, adopt, and prioritize these recommendations. In considering and prioritizing these recommendations it is suggested that Adult Mental Health Services balance recommendations related to improving case management *and* those on enhancing the system of care. While both approaches are necessary, it is acknowledged that the system has limited capacity to make all desired changes and enhancements. It may be that strategies to improve the system of care may have more of an impact on positive client outcomes than direct enhancements to the case management programs themselves. For example, clear expectations for and better integration with acute hospital services may allow case management programs to increase treatment effectiveness and efficiency. This could both improve outcomes and increase the time case managers have to serve their clients.

6.1 Strategies to Increase the Effectiveness of Case Management Programs

The following recommendations are based on the consultant's assessment and findings regarding case management services in San Diego's Adult/Older Adult Mental Health System. These recommendations address the question of "how *program design* supports the capacity of case managers to serve clients and improve client outcomes." The following recommendations seek to improve the effectiveness of case management services by positively impacting the capacity of case managers to improve client outcomes. Some of these recommendations may be straightforward to implement while others will involve considerable time and resources.

Implement Evidence Based Programming

Incorporating evidence-based interventions into current program initiatives will support developing a service delivery system that integrates PSR programs.

Recommendation

6.1.1 Implementing or further developing evidence-based programming will take additional resources. Current budget constraints may make it difficult to add costly initiatives at this time. However, it is recommended that the county administration determine which of the following programs the county would like to develop or enhance, prioritize these initiatives, and respond to funding opportunities as they arise.

a) Clubhouses – have been demonstrated to be well accepted and utilized by mental health consumers in the system. Further development could add elements that are consistent with the Fountain House Model

b) Dual Diagnosis Treatment – by continuing to establish the Comprehensive Continuous Integrated System of Care (CCISC) dual diagnosis treatment model in all mental health services and integrating these efforts throughout the system of care

c) Individualized Placement Services – by implementing this supported employment model into case management programs. Further research on this model that has been repeatedly demonstrated to be the most effective approach for mental health consumers in obtaining competitive employment is currently underway at UC San Diego.

d) Multi-Family Group Programs – by training staff and organizing this group modality that could be developed in a variety of mental health programs.

e) Early Intervention Strategies – that have been developed internationally and show considerable promise at reducing stigma of Schizophrenia and other psychotic disorders, changing the health seeking behaviors of young people who experience psychotic symptoms, reducing the duration of untreated psychosis, and improving outcomes.

f) Support for Family/Consumer Organizations and Alternative Programming – by providing concrete support for strengthening family and consumer support organizations and alternative programming to the formal mental health system that these groups design, develop and manage.

g) Recovery Oriented Clinical Tools. Carefully monitor how the WRAP and SanDMap initiatives support client recovery and how they assist providers understand the recovery process. Incorporate the consultation of the client community to carefully implement these tools.

Improve Capacity For Strategic Decision Making

Developing effective case management services requires that strategic information be provided in a timely fashion to decision makers at all levels of the delivery system (from clinical supervisors to top system management). Effective management tools are critical to support appropriate decisions for further program development and implementation.

If the county adopts a plan to develop an integrated regional case management services, program managers will be needed who can use management tools (i.e., reports and analytical ability/experience) to identify effective case management services. While it may take several years to implement the regional system vision, it would be useful to develop case management leadership capacity for these regional services. The recommendations found below have a role in developing leadership capacity through the use of management tools that support effective administrative decisions.

Recommendations:

6.1.2 Improve capacity for strategic decision-making

6.1.2.1 Establish a committee to develop a unified vision for case management programs and monitor the planning and implementation process.

- Include consumer and all case management leadership including that of the county operated services, contracted services and outpatient services. Establishing priorities and implementing any of these recommendations in this report will require a clear, coherent, and consistent approach for all services. Therefore it is necessary to have a unified approach through all case management services for both implementing case management services and integrating them within the larger system of care.

6.1.2.2 Encourage program managers and administrative staff to provide and/or supervise direct case management services.

- This recommendation is based on experience - the best way to learn to provide effective case management services is to provide the services and have opportunities to talk about this work; the best way to understand how a system of care actually works is to directly work with clients who are receiving the services. By having program managers in case management and outpatient programs spend a portion of their time providing direct services, the county will develop a cadre of leadership staff who have a deep knowledge of this work. Similarly, qualified county administrative staff who carry a very small caseload (no more than one or two clients) or who provide clinical supervision will also develop both a direct knowledge of the complexities of this

work as well as an understanding of how the system of care does and does not support this work.

Establish Measurable and Relevant Performance Standards

Traditional performance measures for case management programs provide some useful information about the functioning of programs, but have little bearing on the effects of services provided to clients. These measures often include:

- Hospitalization rates for clients served
- Staff productivity (50% to 60% of time providing direct services are the standard in other settings)
- Client satisfaction rates (Less than 85% satisfaction can indicate problems)
- Medi-Cal billing rates (60% is an expectation in some intensive case management programs with a primarily Medi-Cal eligible population)

6.1.2.3 It is recommended that the county establish measurable and relevant performance standards. Develop a methodology to measure some or all of the following performance measures:

- Reduction in hospitalization rates for clients, pre and post admission to the case management program.
- Rate of engagement of clients referred to case management programs by comparing the clients referred to the service to those who are receiving services both one month and six months after referral.
- Ability of the program to maintain clients in long-term services
- Number of families with whom the case manager has contact
- Number of clients who are involved in meaningful activities including those who: obtain employment (full/part-time, stipended), or are in school or who volunteer to provide community services.
- Number of clients who move from structured settings to independent living
- Reduction in re-arrest/incarceration for clients with criminal justice involvement
- Reductions in client use of drugs and alcohol
- Family and provider satisfaction with case management services
- Balance of direct client services with collateral services to family, natural support system members and other providers. (While there are no established proportions established this is an indicator that case managers are working with both the clients and the clients' support systems)

6.1.2.4 Develop report cards for all case management programs. Information should include:

- Routine management information reports on total caseload, caseload size, units of service, overall client and unit costs as partially outlined in

the chart in the "Description of Case Management Services" in this report. This information can be used to monitor changes in activities of each program over time, and to compare programs with each other. This information should also include productivity of each clinician who provides case management services.

- Client Satisfaction Surveys
- Family Satisfaction Surveys
- Provider Satisfaction Surveys by staff in hospital, Clubhouse, Residential Care Facilities and others that describe their satisfaction with and recommendations for case management services

Integrating Psychiatric Treatment in Case Management Services

6.1.3 Integrate medication treatment into case management services.
This is a key recommendation. As discussed above, the clinical case management model is designed to integrate treatment methodologies. Experience suggests that integrating psychiatric treatment with other services provided by case managers is a key to successful outcomes and efficient service delivery, as staff share the culture and the accountability for serving the client. This has the potential to be achieved without additional resources as both the case management and psychiatric services are already provided and paid for within the system of care; however, the current situation is informal and does not structurally enhance service integration. Case managers currently work extensively with Fee For Service psychiatrists, and formally connecting those services, and incorporating nursing services, has the potential to make these services more efficient. It is estimated that well over a third (over 1,000 open cases) of the current community-based case management clients are served by Fee For Service private psychiatrists.

- While logistically complicated and challenging to implement within the current system, this recommendation can be achieved redirecting existing resources and costs to case management services in one or more of the following ways:
  - Hiring physicians within the program budget or developing an arrangement with a Fee For Service Provider to provide services for a group of clients on-site at the case management programs.
  - Including nursing staff who can administer medications within the program budgets.
  - Implementing a "Meds Mostly" concept in case management programs (in which stable clients mostly receive medication services but have an assigned case manager who will provide more intensive services when clients are in crisis or have other needs that cannot readily be met by the medical staff).
  - Outstationing county case management staff into outpatient clinics with integration to the clinics' psychiatrists and nursing personnel.
  - Offer more per diem employment opportunities for psychiatrists to work for outpatient clinics (by redirecting funds that would otherwise

have gone to the Fee For Service sector), offering increased opportunity for community service and more role diversity.
- Where Fee For Service psychiatry remains as is in working with residential care residents, develop standards and expectations for the psychiatrist role (as San Francisco has done).

6.1.4 Hospital admitting privileges for psychiatrists. Develop a process to allow ACT psychiatrists, and psychiatrists in other case management programs, to have admitting privileges at the hospitals where their clients are admitted.

Additional Recommendations for Enhancing Effectiveness

6.1.5 Implement transitional case management services clients being discharged from the START acute residential treatment programs as indicated in the program's description.

6.1.6 Assign case manager to homeless clients who otherwise meet eligibility criteria even if they cannot provide an address.

6.1.7 Further develop partnerships with client families and natural support system members by:
- Training staff to identify client family members,
- Incorporating family relationships in all client assessments,
- Changing policies that exclude clients who have families as conservators or other involvement with clients
- Training staff to provide psychoeducational programming both informally and through implementing Multi-Family Groups

6.1.8 Further develop opportunities for clients to obtain employment by
- Assessing all clients' interest in working
- Incorporating specific strategies in service plans for all clients who express an interest in working
- Increasing access to the existing vocational programs for case management clients
- Developing Employment Counselor positions in all case management programs that would provide Individualized Placement Services Supported Employment Services. (This model is currently being implemented at UC San Diego.)

6.1.9. Consumer employees in all case management programs. Develop or fill mental health consumer positions to provide direct client services in case management programs.

6.1.9.1 Establish a peer counseling training program, using San Diego NAMI Peer-to-Peer or the Alameda County Behavioral Health Services BestNOW! or other similar curriculum. Recruit from the Clubhouse system.

6.1.9.2 Consult with the Alameda County Behavioral Health's BestNOW! Program or with the Contra Costa County Mental Health Department's SPIRIT Program for client consultation on:

- Establishing a consumer employment support network for consumers working and volunteering at all levels of the mental health system.
- Developing a case management employee dialogue program to assist with co-worker's and supervisor's questions that arise when consumers are hired to be part of the treatment team.
- Creating job classifications and strategies to fund positions.

6.1.10 Improve case management training opportunities by

- Involving case managers in defining their training needs
- Encouraging line staff to develop trainings for their colleagues in topics in which they are interested.
- Assuring that individual clinical supervision is available on a regular and continuous basis
- Developing peer supervision opportunities
- Allowing staff paid time off for participating in approved training that is related to their work and not provided by the county

6.1.11 Increase case managers' capacity to work with dually diagnosed clients through training and program implementation consistent with the CCISC model, including:

- Integrated assessments for alcohol and drug use and abuse
- Training on stages of change interventions such as motivational interviewing and other interventions to encourage the reduction of the use of drugs and alcohol
- Offer dual diagnosis groups for case management clients with co-occurring disorders
- Developing linkages with community substance abuse services and particularly with AA and NA groups that are supportive of individuals with mental illnesses

6.1.12 Increase access and integration with services that case managed clients regularly need and/or use including

- Acute Psychiatric Hospital Units
- Residential Care/Independent Living Facilities
- Day Rehabilitation/Club House Programs
- Primary Care Medical Services
- Fee For Service psychiatrists

6.1.13 Increase case managers' awareness of the appeal process when denial of long-term care placement authorizations would, in the case manager's clinical judgment, create a dangerous situation for the client or the community by

- Utilizing a formal appeal after the case is reviewed by the case manager's supervisor
- Establishing a case conference to bring all responsible and interested parties to review the client history and placement options

6.1.14 Re-establish or increase liaison role of case managers in the County Case Management Program including:

- Clarifying the expectations of the liaison role
- Developing a mechanism for all staff to obtain information from the program liaisons
- Assigning administrative responsibility for following through on issues raised by the liaisons
- Monitoring the continued functioning of this responsibility

6.2 Strategies to Increase the Efficiency of Case Management Programs

There are a number of actions that the county can take to improve the efficiency of existing case management programs. Efficiency focuses on how resources are used internally to support program performance. These may apply more to some case management programs than others, some are more readily achievable than others, and they are not organized according to any priority.

Recommendations:

6.2 Increase the Efficiency of Case Management Programs (resource utilization strategies)

6.2.1 Restructure caseload sizes:

- Increasing the client-staff ratio for clients who are placed in Residential Care Facilities and for whom there is no plan or interest by the client to move to independent living; and
- Reducing that caseload size for clients who are living independently and/or are in residential care and planning to move to and independent living setting.
- Develop criteria for evaluating clients on conservatorship and living in the community, with a goal of further reducing the number of clients who are conserved.

6.2.2 Reduce the paperwork burden of case managers by

- Appointing a committee of case management staff volunteers to review all of the paperwork requirements and make recommendations for reducing the amount of time required to provide necessary information.
- Hiring appropriate staff (perhaps in replacement of case management positions) to complete the logistical (paperwork) functions of the Representative Payee role.

- Establishing a system of “banked cases” for clients who require infrequent and only occasional contact so that all of the paperwork required to reopen a case is not necessary when they request services
- Developing a plan to implement a computerized charting system throughout all mental health services

6.2.3 Increase tools for case managers to use to fully implement their roles:
- E-mail/internet Access
- A Petty Cash Fund in all case management programs that allows for the disbursement of small amounts of money as a grant or a loan to clients to avert a crisis or otherwise support implementation of the service plan
- Access to cell phones when working in the community
- Transportation for both case managers and clients

Set 7: Improve the Integration of Case Management Services with the Mental Health System (service-level integration)

Case management is a methodology to integrate services for multiple need populations at the level of the individual client. Therefore, the work of case managers is not just with clients. Another major role, that is equal in importance to working with clients, is developing relationships with families, other providers and natural resources to support client access to all of the resources of the community. However, a case manager’s ability to assure access to other resources is dependent on these providers’ ability and willingness to work with both the client and the case manager.

The responsibility of a public mental health system for its multiple need clients is to support integration of and access to services at all levels, client, program and system of care. Recommendations at the system of care level include both strategies to integrate programmatic efforts within the existing services system as well as suggestions to establish, increase the capacity, or further develop evidence-based programmatic interventions. Recommendations at the policy level suggest strategies to fund the recommendations in this report, and to develop leadership cadres to support system change and development.

If case management is defined as a comprehensive treatment methodology, then in a mental health system with numerous programs and services that a client uses, it is not just the case manager who is responsible for implementing comprehensive care. While the case manager is the single point of accountability with responsibility for developing a care plan and monitoring and responding to the outcomes, the client and case manager are both dependent on many other providers and resources to achieve these outcomes. Therefore, every program and provider in the mental health system has responsibility for carrying out the comprehensive treatment plans of case management clients.

While case manager's role includes advocacy for their clients with other providers in the system, they have very limited authority to effect changes in how these providers operate either for their particular clients or for clients in general. Integration of care at the system level is the responsibility of the mental health services administration. Therefore, a central recommendation of this report is for the mental health administration to restructure case management services and integrate services within the mental health system into a seamless system of care. This is achieved by clarifying the role of all programs, supporting effective working relationships among all elements of the service system, and providing continuous monitoring and refining of these relationships. It is suggested that a regionalized mental health system will promote system of care integration because smaller entities and groups of services can more readily relate and adapt than larger ones. A major administrative role of the proposed Comprehensive Recovery Centers is to integrate their services with other resources in their region.

Nevertheless, it is suggested that the recommendations for service system integration be implemented in stages. While these issues are typical in public mental health systems, they also negatively impact the effectiveness of the services that are available, waste precious resources, increase staff burden and burn out, and, most importantly, limit clients' opportunities to reintegrate successfully into community life.

This section also suggests that the county develop forums and feedback loops to enhance its capacity to consider, recommend, implement and monitor strategies to enhance the integration of services provided by case managers and care coordinators. Some specific goals, based on experience and best practices in other mental health jurisdictions are suggested.

The scope of this assessment and report does not allow for an in-depth analysis of the providers or service systems described in the section. The conclusions of this section are, therefore, circumscribed by the limitations of the information gathered.

Recommendations

7.1 Psychiatric Hospitals and Emergency Psychiatric Units

Acute psychiatric services are an important and costly element of any mental health system. It is necessary to use these resources effectively and judiciously. In the San Diego County Mental Health System the perceived improvements between the acute services and community services could address the following outcomes.

1) Clarifying for all providers the roles and expectations of both acute and community based staff

2) Improved access to admission, with the judgment of clinicians about the need for hospitalization being accepted in nearly all cases
3) Immediate notification of hospital admission for all clients (regardless of the hours the program currently operates with an eventual expectation that all case management/outpatient services will have 24 hours access to a clinician)
4) Face to face discussions between case managers and hospital staff and clients during the admission with a goal of agreement on treatment and discharge plans
5) Provide admitting privileges for psychiatrists of case managers so that they can provide continuous treatment for their clients, or discussion and agreement between the inpatient and outpatient treatment psychiatrists on medication treatment
6) One working day notice, to community case managers and care coordinators who are responsible for ongoing care, prior to discharge (or notice as soon as possible if the client is likely to be discharged by a court decision or if the client leaves AWOL or AMA)
7) The ability for emergency psychiatric units to keep clients overnight (but within the 24 hour limit) to avoid admissions of individuals whose symptoms may be primarily substance abuse related
8) Around the clock access for emergency psychiatric unit staff to community providers who can discuss all case managed clients, their needs, and possible alternatives to hospitalization.
9) Around the clock mobile crisis capacity that can provide face-to-face review of all admissions recommended by emergency psychiatric units and who can develop alternatives to admission as well as arrange follow through for clients who are authorized for admission with a goal of reducing the length of stay

7. 2 Residential Care/Independent Living Facilities

In this report the term Residential Care is used for what are commonly referred to as Board and Care Homes. This is because Residential Care Administrators throughout the State are indicating that the licensing category that they work under is called Residential Care and that there is no such entity as Board and Care. In addition, they perceive Board and Care as having a negative connotation that unfairly represents them. While it is acknowledged that there is a great disparity in the quality of care available in Residential Care Homes, this is in some part due to underfunding, neglect, and insufficient attention to cultural differences between Residential Care Administrators and the mental health professional community. Therefore, this report consistently uses the term Residential Care that in San Diego County appears to represent a great resource that is not adequately understood, supported, utilized or appreciated.

The available information does not clearly explain Independent Living Facilities. They appear to be boarding homes that provide room and meals. Nevertheless,

they appear to be one of the major housing resources available to mental health consumers in the county.

The recommendation regarding these essential supported housing resources is to assign administrative responsibility for the development of strategies and mechanisms to consider the following:

1) Develop a regularly occurring venue for meetings between system of care representatives at all levels and Residential Care Administrators to learn the administrators' needs and issues with case managers and other service providers
2) Establish an inventory of Residential Care and Independent Living Facilities
3) Develop a mechanism to know and to keep information about current vacancies for facilities in the system, and the ability to coordinate placements based on client needs and wishes
4) Assess all case management clients in Residential Care for their interest in moving to more independent living, and develop a plan for them to do so
5) Provide training on mental illnesses, their treatment and other issues for Residential Care administrators and their staff that is required to maintain licensure.
6) Provide Supplemental Funding at different levels for the following purposes:
    - Increasing expectations for administrators to work collaboratively with case managers and other providers
    - Augmenting some Residential Care Facilities so that they can provide a transitional level care between institutional services and basic level Residential Care Homes.
    - Keeping these facilities from closing and from losing a valuable housing resource

7.3 Primary Care

The medical morbidity rate for people with serious mental illnesses has been shown to be three times greater than for the general public. Failure to prevent and treat medical conditions often has a dramatic negative impact on the outcomes of mental health treatment. At the same time there are numerous barriers that people with mental illnesses experience to obtaining high-quality medical services.

It is recommended that the county mental health administration develop mechanisms to assure access to primary care services for its clients. Possibilities for improving primary care access for mental health clients could occur through the following or other mechanisms:

- Memoranda of Understanding between the Adult/Older Mental Health Services Division and the Department of Health and Human Services primary care clinics and services
- Agreements for access of mental health clients to primary care providers that accept Medi-Cal and Medicare payment
- Integration of primary care services in mental health programs

7.4 Community Resources

There are numerous community resources on which clients with serious mental illnesses depend for successful community life. Some of these include adequate and affordable housing, accessible transportation, legal services, recreational resources, educational programs, employment opportunities, and others. The county mental health administration has developed administrative roles to develop more accessible housing and transportation.

It is recommended that the county administration continue to identify, prioritize and provide administrative support to address access to community resources needed by its client population.

7.5 Communication and Coordination between Staff and Programs

Focus group members cited numerous instances of poor coordination and communication between case management services and other mental health programs. There were specific references to issues between case management programs and Day Rehabilitation Programs, Clubhouses, and Care Coordinators in Outpatient Services. The following recommendation is in addition to the recommendation above about fully establishing the liaison roles in the County Case Management Program

It is recommended that the county administration establish regular opportunities for management/providers from all modalities to consider ways to improve communication and address issues to improve coordination of all mental health program modalities. These mechanisms could be integrated with those that address acute services integration recommended above.

Set 8: Strengthen the System of Care

It is clear that many decisions about funding streams affecting service delivery are made at State and Federal levels. Policy decisions that impede the ability of counties to integrate services are beyond the control of county public health administrations. In addition, the sluggish economy might produce reduced State and Federal revenues for several years.

Nevertheless, there are strategies that the county can pursue to support integrated services at the level of the system-of-care. Topics in this section address strengthening the system of care by focusing on funding, the political climate, and opportunities for leadership development. These recommendations suggest that the county develop a funding plan, a political support plan and a leadership development strategy to obtain the resources and the political support necessary to implement the Case Management Strategic Plan.

Funding Development Plan

The implementation of each and every recommendation in this report will require the county to expend resources. Even a policy change requires administrative time. Also, implementing a policy change usually means that staff effort is redirected and that some activities or services that were previously provided will no longer be available or will be provided to other populations. The recommendations for integrating care that are described throughout this report require considerable staff time, at all levels, that will utilize staff hours that could otherwise be available to provide or administer direct client services. Many of the recommendations are for restructuring and expanding existing services or creating new ones.

It is suggested that there are a limited number of ways that additional resources can be made available to enhance public mental health services and, thereby, improve client outcomes. These include: providing services more effectively; becoming more efficient; redirecting resources from some programs to create different services and expand others, and obtaining additional funding. The recommendation found below incorporates all of these resource enhancement strategies.

Recommendation

8.1 Establish a Funding Development Plan to support implementing the recommendations in this report. A minimum set of strategies might include:

1) Prioritize and implement the recommendations in the report designed to improve the effectiveness of existing case management services (Recommendations 6.1)
2) Prioritize and implement the recommendations suggested to increase the efficiency of county mental health services (Recommendations 6.2)
3) Develop a plan to redirect program resources to evidence based community focused programming. Strategies that have been implemented in other mental health systems for achieving this goal include diverting resources from
    a. Long and short term hospital and institutional services
    b. Rehabilitation Day Treatment Services
    c. Long-term Residential Treatment Programs
    d. Short-term Transitional Case Management Services

e. Other local services that have not been demonstrated to be cost effective

4) Implement a systematic and broad-based approach to obtain additional funding to expand and add prioritized programming. This would include:
   a. Implement strategies to maximize Medi-Cal and Medicare participation that can include:
      i) Training, supervising and monitoring staff billing practices to assure that all allowable services are billed to Medi-Cal
      ii) Implementing practices that support eligible clients in applying for and receiving SSI and other entitlements
   b. Systematically preparing proposals that respond to governmental requests for applications, and to both philanthropic and corporate foundations. This recommendation can be supported by establishing a fund development role by either creating a full or part time fund development position, or contracting with a funding development consulting firm. It has been demonstrated that the investment of less than $100,000 per year can consistently produce over $1 million per year in additional revenues.

Community Support Strategies

For this discussion it is assumed that every dollar expended for public mental health services is made available through a political process. Political decisions in the State of California over the past 50 years have resulted in the state moving from being a state that others looked to for direction and ideas, to a state with one of lowest per capita funding levels for mental health care in the nation. Political decisions in San Diego County have resulted in this county having one of the lowest per capita funding levels in the State of California. This means that San Diego County has an underfunded mental health system in a State that underfunds mental health care. In addition, the burden on public mental health services is greatly affected by the discrimination against people with mental health disorders in health insurance systems. This issue has only been partially addressed by parity legislation in California.

The responsibility of public health departments goes beyond providing healthcare services for indigent and low-income populations. This responsibility has historically been defined to include improving and maintaining the health of the entire community through health promotion, prevention of disabling conditions, and by developing methodologies to improve outcomes in healthcare services. As public mental health services are, by definition, politically funded entities, it is their responsibility to develop the community support needed to meet their responsibilities.

Recommendation

8.2 Strategy for community support. The San Diego County Adult and Older Mental Health Services Division develop a community support plan with a goal to increase support and funding to implement the recommendations adopted in the Case Management Strategic Plan.

Strategies that have been developed in other jurisdictions for political support for public mental health services include:

1) Educate the public about mental illnesses, and the benefits of treatment and the need for accessible services
2) Define treatment outcomes in terms that are consistent with the political culture such as
    a. Reducing dependency on public resources
    b. Getting disabled people back to work and increasing the tax base
    c. Increasing self-sufficiency and personal responsibility
3) Identifying local political, business, and other leaders who have personally struggled with a mental illness or with that of a family member and educating them about and obtaining their support local county mental health initiatives
4) Developing liaison roles between Mental Health Board members and the Board of Supervisor members who appointed them
5) Obtaining Support from Family and Consumer organizations for initiatives to improve public mental health services
6) Educating and obtaining support from mental health advocacy, professional and other organizations

8.3 System of Care Leadership Development

A basic tenet of modern quality management is to decentralize the capacity of the system to implement functions effectively, and provide informed feedback to the leadership that exists at the top of the organization. This requires the development of leadership cadres at all levels; from line-staff through the offices of the executive. The need for leadership development surfaced during focus groups and stakeholder interviews in three ways.

First, a common theme heard in the case management focus groups was a feeling of intense disempowerment and estrangement from the county administration. Case management staff felt that their ability to systemically problem-solve, implement new procedures and “be heard” when encountering serious operational problems was compromised. A suggestion was made to introduce a feedback loop between county and contract case management staff and the program administrators in charge of this system. Another consideration is for the MHS Administration to review the bifurcation of the case management system and consider one administrator to oversee the county and contract operated programs.

Second, the size of the county suggests a mechanism to problem-solve resource issues on a regional level. Stakeholder and focus group interviews, held in each region, reported a lack of effort to systematically identify and coordinate services. Housing, transportation, access to primary care and other non-mental health services are better solved when a regional leadership capacity is recognized and can collaborate with the resources of the central office via an adult system of care workgroup. Local opportunities can be best identified by staff and managers in the field.

Third, the county has put considerable effort into PSR education and training, and has recently started a Psychosocial Rehabilitation Advisory Work Group. At this point, the system is ripe to establish a forum that can be used to develop a common language and vision for wellness/recovery and to establish a game plan to develop the system of care within that vision. This is a place where the county collaborates equally with client leadership in a high profile position. A wellness recovery task force is a broad stakeholder work group that is currently used by the following counties to develop and implement a system of care driven by recovery principles: Contra Costa, San Francisco, Kern, Solano, San Bernardino, Sonoma, Humboldt and Mendocino.

Recommendations

8.3.1 Review and address the dual leadership that administers county and contract programs, as a bifurcated system adds to the complexity of restructuring an integrated regional model.

8.3.2 Establish Regional Case Management Work Groups, or expand the existing Regional Provider Meetings to focus on case management plan implementation. Set up a multi-organizational and problem-solving work groups in each region whose task is to identify and prioritize the system of care development challenges faced in each geographic area. Membership would include providers, consumers and family members. Representatives from non-mental health systems would be invited to meetings to troubleshoot collaboration challenges. This process will support the regional coordinators and central staff who support the education, employment and transportation program development.

8.3.3 Establish a Wellness/Recovery Task Force or redefine the PSR Advisory Work Group. Develop a multi-stakeholder wellness recovery task force to provide a forum to develop a common language about rehabilitation and recovery and to develop a short and long-range vision for the system of care. This task force shall include clients, family members and representatives from each sector of the delivery system. After establishing consensus for a vision, the task force can make recommendations for the implementation of a rehabilitation and recovery-based adult system of care.

8.4 Consumer/Family Leadership Development

Systems of Care need to incorporate the experience and wisdom of their "customers" in order to change. Consumers and family members hold important information about access and quality – these stakeholders can assist with both the problem definition and in problem resolution phases of program planning. In addition to involvement in working committees, consumers and family members are needed as collaborators in system change efforts such as wellness/recovery task forces; work groups that specialize in a system redesign effort (such as a case management redesign team); or on groups that consult with specific individuals (such as the mental health director).

San Diego has an unusually strong and collaborative client group and family core. This recommendation seeks to encourage the AMHS administration to work as closely as possible with this talented group of people.

Recommendations

8.4.1 Identify consumer/family roles in the system of care. Talk with the consumer and family leadership and create a plan for their involvement in the mental health system. Make a list of system redesign efforts and innovative programs that would benefit from the perspective of a "user" of the mental health system. Increase efforts such as the 'Client and Family Advisory Council' that is currently in use by some case management programs.

8.4.2 Establish a plan to reimburse consumers and family members for costs associated with attending meetings.

8.4.3 Provide training to support effective committee participation. Contact the California Network of Mental Health Clients to find out about their SAMHSA sponsored leadership training course for clients (also contact the Alameda County Behavioral Health Services BestNOW! Peer Counseling program about their leadership curriculum. Contact NAMI-SD to find out about leadership training classes for family members.

ATTACHMENTS

- **References**
- **California Mental Health Directors Association; Adult System of Care Framework; Sept 2000**

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Adult System of Care Framework

Adopted by the California Mental Health Directors Association
September 14, 2000

The California Mental Health Directors Association has designed this framework to articulate our vision of an ideal, fully funded, culturally and linguistically competent, age appropriate, and gender sensitive Adult System of Care (ASOC). We have undertaken this effort to answer the question, if we could design the ideal ASOC and had the funding to implement it, what would it look like?

In the course of formulating our response, we have also had to answer questions concerning who would it serve, the values and beliefs on which it would be based, the services it would provide, and how would it provide them. This framework is designed to be flexible, and recognizes that even if it were possible to implement an ASOC in all counties, not all public mental health systems would need or desire to implement all of the service elements that we have included in this framework.[1]

This framework identifies mechanisms for achieving optimal and high quality services and provides guidance on policy and program development activities at the state, regional, and local levels of service delivery. We have based this framework on a coherent set of values and beliefs that holds collaboration with consumers, families, and communities as well as our partner agencies, at its core. Although a fully funded ASOC would require significant increases in funding from state and local governments, most of the conceptual elements presented herein require no additional fiscal resources.

A culturally competent, gender sensitive, and age appropriate ASOC acknowledges, embraces, and enjoys the unique talents, gifts, and experiences that each consumer brings to the system, and recognizes that each has unique needs. A culturally competent ASOC incorporates a full understanding, awareness, and sensitivity to the unique cultural and linguistic needs of the consumers it serves. It fully integrates the principles and values of cultural competence in a seamless fashion.[2] A gender sensitive ASOC incorporates a

[1] In order to provide for such flexibility, and in view of the prevailing inadequacy of resources, it is important to emphasize that this document is not a set of regulations or review standards to be imposed on local programs. It is, rather, an articulation of values and goals to which mental health directors are strongly committed.

[2] Cultural competence is defined as a set of congruent practice behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enable that system, agency, or those professional and consumer providers to work effectively in cross-cultural situations. The cultural competence continuum is:

- Cultural Destructiveness
- Cultural Incapacity
- Cultural Blindness
- Pre-Competence

full understanding of gender based issues, and integrates that understanding into its planning to serve the differential gender based needs of consumers within diverse cultures. And an age appropriate ASOC recognizes that the needs, experiences, and life situations of children, adults, and older adults are different.

This framework establishes adult service delivery designs that support effective, high quality, culturally and linguistically competent, age appropriate, and gender sensitive recovery-oriented services for adults and their families[3] that can be used independently or in tandem with community-based supports. A challenge to the development of an effective ASOC is the capability to incorporate and allow for varying conceptual and treatment approaches. As mental health delivery systems are publicly funded, they must be designed to be inclusive and accountable to every segment of the community. In so doing, ASOCs must be designed to incorporate differences, and to address those concerns such as established laws, customs, traditions, and practices that systematically result in race, gender, and age based inequalities in institutions and society; as well as other types of discrimination,[4] stigma, oppression and other systemic practices, which have historically served as barriers to access and treatment. The needs of consumers drive the access to and duration of services designed to assist consumers to address and negotiate multiple socioeconomic, stigma and age and gender-related barriers faced by those in recovery from mental illness. This framework is dynamic, such that individuals can enter or access services and reenter or exit the system at any point, depending on their needs. That is, services do not follow a particular order, but build bridges with the community in which the consumers and their families live. Mental health promotion, wellness, and prevention activities are essential components of the continuum of available services, and increase direct services and recovery activities by increasing community awareness about mental health issues and the resources available within Systems of Care.

ASOC PARAMETER I: VALUES AND BELIEFS

VALUES AND BELIEFS

- Consumers can and do recover. Human beings are resilient. Support and challenge are both important for recovery
- Recovery is a personal journey anchored in a range of interpersonal relationships, including families, children, peers, friends and significant others

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- Basic Competence
- Advanced Competence

[3] Families are at the core of a successful partnership in recovery. We define 'family members' broadly to include relatives, children, peers, mentors, friends, caregivers, and significant others and domestic partners as determined by individual consumers. ASOC services must support the role and requirements of parenting that most often impact women. ASOC services should include consumer-driven recovery plans that honor and protect consumer privacy, rights, and choice with regards to the involvement and re-involvement of family members.

[4] Discrimination: The behavioral manifestation of prejudice involving the limitation of opportunities and options based on a particular criterion, i.e. race, sex, age, class, disability.

- The cultural identities and worldviews of the consumers shape health and healing beliefs, practices, behaviors and expectations. Wellness is therefore, uniquely defined by each individual and each cultural group
- The well being of individuals is seriously impacted by the abuse of alcohol and drugs, overshadowing their innate strength and distancing them from their families and communities
- The mental health of individuals, families, and communities is impacted by poverty, oppression, racism, gender and age bias, violence, and other negative social conditions. Stigma associated with mental illness has a similar negative impact on consumers
- The ASOC acknowledges the power differential between the provider and consumer. Power can be put to the service of healing when it is kept in balance and used in the service of consumers.
- Services are strength-based, recognizing that consumers with varying strengths, symptoms, communication styles, life situations and cultural values have unique goals and approaches to the recovery process
- Community and family are natural social supports. For the consumer, his or her family and community may be primary points for service intervention and integration
- Spirituality may define well being and should be incorporated into some healing practices. Services must respond to the consumer's unique healing process

VALUE DRIVEN SERVICES

- Services are sensitive to "client culture"[5]
- Services are culturally and linguistically competent
- Services are gender sensitive
- Services are age appropriate
- Recovery is supported by rapid access to high quality clinical services of rigorously demonstrated effectiveness delivered by skilled and motivated personnel
- Services are consumer-driven and provided with the engagement of the consumers, their families, or significant others. Services maintain consumer rights, dignity, and respect, and recognize the unique experience of each consumer
- Mental health promotion and prevention are essential components of a comprehensive system of care
- When communities are unaware of mental health services, culturally competent primary prevention provides essential access to other service strategies

[5] For the purposes of this document, the term 'client culture,' shall be used when referencing the culture of mental health clients. Mental health clients bring a set of values, beliefs, and lifestyles that are molded as a result of their personal experiences of a mental illness, the mental health system, and their own ethnic culture. When these personal experiences are shared, mental health clients can be better understood and empowered to effect positive system change.

- Acquiring quality services, including clinical care, housing, education, employment, opportunities, access to physical health care, and an array of peer and community supports are all critical components of the recovery process
- These components must be supported by strategic advocacy, a commitment to the identification and elimination of barriers, and the allocation and redirection of resources

VALUE DRIVEN LEADERSHIP

- Individuals are eligible for ASOC services without regard to personal characteristics such as race, ethnicity, religion, national origin, gender, sexual orientation, and/or physical disability
- The role of an ASOC is to facilitate improvement in the functioning and emotional well being of individuals by acknowledging, understanding and incorporating the resilience of each individual
- Service agencies that create respectful, supportive, and empowering organizational cultures, foster quality care delivery, collaboration with other services, and partnerships with the community
- Service quality requires the development of appropriate benchmarks and accountability, with ongoing monitoring for consumer satisfaction and relevant clinical structures, processes and functional outcomes for all consumer groups
- Efficient use of mental health funding means serving consumers in the least restrictive, most normalizing, most cost-effective manner possible, including the development of residential alternatives to all levels of institutional care, enabling the system to extend services to a larger client base

ASOC PARAMETER II: SYSTEMS OF CARE DEVELOPMENT

This parameter defines the aspects of an ASOC's organizational infrastructure that are required to transform a set of adult services into a gender sensitive, culturally and linguistically competent, age appropriate system of care. The aspects to which we refer are: collaboration and partnerships, governance and organizational structure, strategic planning, human resource development, and accountability.

Collaboration and Partnerships

The success of a recovery-based ASOC is anchored in its providers collaborating with consumers, families, and communities and requires inter-organizational, inter-agency, intra-county and community collaboration as well. Collaboration must occur between agencies and/or individuals that are stakeholders in a consumer's life in terms of policy, planning, and service delivery.

Local inter-agency collaboration begins with and is dependent upon state level inter-agency collaboration. State agency commitments must be clearly communicated to local agencies. Many mental health departments rely on relationships with other government agencies to offer access to important services and supports like housing, employment, and education. Collaboration will be stronger if requirements and incentives to collaborate are similar across local agencies, and this in turn will require commitment and collaboration by state departments and agencies. The role of the State Department of Mental Health includes assisting local agencies in designing effective supportive services that accommodate consumer needs and in establishing collaborative relationships that work.

Formal and informal collaboration and partnerships with community-based and grassroots organizations are necessary to build the organizational infrastructure needed to ensure that consumers have access to a wide variety of therapeutic and support services and opportunities for community integration. This includes the strengthening of family, parenting, and consumer peer support networks. Formal contracting partnerships with community-based organizations can offer rich and seamless services for consumers. Established culturally and linguistically competent, gender sensitive, age appropriate community organizations and agencies that may not now provide mental health services can be used to create or expand mental health services. Informal bridges between mental health departments and a variety of local social service and peer support networks give consumers in recovery broader opportunities to settle into appropriately designed community supports.

Governance and Organizational Structure

The local public mental health authority serves as the entity responsible for coordinating the development of the ASOC. This authority has the responsibility at the policy and program level to coordinate services that may be provided by the local mental health department (i.e. therapeutic and support services) and responsibility for linkages with services and supports provided by other local agencies, contractors, and/or local service and support organizations (i.e. housing, education, employment, and peer support networks).

The establishment of ASOC Policy Councils is essential and must reflect the diversity of the local area and represent all mental health stakeholders. Inter-agency collaborations need to occur at the policy, program and operational levels. Successful governance is demonstrated by:

- **Local mental health boards or commissions that include consumers and families who report to the governing body on mental health issues within the system**
- Implementation of a culturally competent system of care

- Encouragement of parity representation by diverse populations reflective of their local communities, from line staff to management
- Inclusion of consumers as employees throughout the organization including management
- Strong agreements on the policy level, including shared organizational goals and formal interagency partnerships, marked by written agreements such as Memoranda of Understanding
- Integration and collaboration on the service delivery level
- Clear protocols for data sharing that respect client confidentiality
- Common referral forms for all gateway agencies that identify potential clients
- Co-location of services, where appropriate and intended to increase access
- Shared staff, where collaboration, access, and effectiveness are increased
- Resource sharing
- Development of collaborative care teams that meet regularly to coordinate care

Strategic Planning

Long-term planning and organizational development will include the Local Mental Health Board or Commission, consumer and family representatives, public and private community-based providers, community members, and Children's and Older Adults' Systems of Care. The resources, including funds, staff, and skills to do collaborative program building work, are not present in all cases today. Resources are needed to work with the community to lay the groundwork to provide for the clinical and non-clinical needs of consumers and their families.

Local public mental health authorities must assemble the partners to develop a framework for an ASOC. This framework will guide regional and local resource allocations, and will allow utilization of limited and categorical funds to build a culturally and linguistically competent, gender sensitive, value-based, treatment-effective, age appropriate, and coherent system of care.

Human Resource Development

Recruitment, training, and retention of culturally competent, ethnically diverse staff is a large and growing problem in the public mental health system. Strategies for recruitment, development and retention of staff must be a part of ASOC design and implementation. Training of current and new staff in the values and strategies of a recovery-based delivery system is a need for organizational development. Training is also needed for ongoing system operation. Training must be a regular part of every ASOC project. Training must include staff, consumers, family members, the public, collaborative partners, academic and research institutions, and the recovery community. ASOC programs must have a human resources component that includes:

- Recruitment, development, and retention of culturally diverse line staff, middle-management, and executive staff
- Designated positions with particular cultural and/or linguistic skills and competencies, with appropriate pay differentials
- Creative workforce development e.g.: Work with school districts to develop human service curriculum at the middle and high school level, coordination of undergraduate/graduate recruitment sessions with ethnic service staff, promoting mental health professions to college and university student affairs officers using professionals and consumers, and development of joint county/university internship programs, where possible
- Creative career development e.g.: Support for front line staff to complete career ladder programs to include consumers and people of color and development of mentoring programs for professional and paraprofessional staff
- Training

Accountability

Accountability for service appropriateness and quality must be guaranteed through development of policy, procedures, and performance outcome data that ensure:

- Access, utilization, treatment and consumer satisfaction for all groups
- Most normalizing and least restrictive treatment levels appropriate to the clinical needs of the client
- The development of service quality benchmarks for all populations that include diverse and underserved populations
- Cultural and linguistic competence
- Gender sensitivity
- Clear and accurate documentation of medical necessity for clinical services
- Clear and accurate accounting of all funding sources and expenditures
- Ongoing monitoring of consumer satisfaction
- Ongoing monitoring of individual and aggregate outcomes
- Sharing of outcomes and other relevant information with local collaborative and use of outcomes to improve service quality
- Availability of effective consumer-friendly and linguistically competent problem resolution processes

Best Practices

Identification, development, promulgation, and adoption of culturally competent best practice guidelines for care must be an integral part of ongoing Adult SOC

design and modification. Best practice guidelines and the treatment strategies are to be based upon empirical evidence discovered through culturally competent and gender sensitive research. An effective ASOC is driven by continuous quality improvement, outcome based measurements and the incorporation of new knowledge and technology.

ASOC PARAMETER III: SERVICE POPULATION DEFINITION

The ASOC service population includes persons who, due to a mental disorder, have a reduction in personal or community functioning, and who are best served in the public specialty mental health system, including persons with co-occurring disorders.

The ASOC service population includes:

- **minors in transition** to the ASOC
- **emancipated minors** and **those 18 and older who are living as adults and**
- **individuals in transition to the Older Adult System of Care**

Services will be provided until the individual recovers, no longer desires services, or would be better served outside the public specialty mental health system. Services must be accessible to persons of all ages within the public specialty mental health system.

ASOC PARAMETER IV: SERVICE ELEMENTS

The following service elements reflect the vision of a culturally and linguistically competent, gender sensitive, age appropriate, recovery-oriented ASOC. This "menu" of service elements has been developed as though full funding would be made available. The full menu may not be achievable for every locality immediately, unless such funding is available. The list of service elements is intended to serve as a guideline for counties in creating a comprehensive system that is responsive to local needs. Expansions and additions of creative services and activities that assist and support consumers are encouraged.

Service elements should reflect the specific needs of the population served. That is, services and service sites should be culturally competent and linguistically appropriate for the demographics of the geographic area served. In addition, design of individual/local systems should ensure age appropriate services and support activities that address specific needs of transitional youth as well as different stages of maturity in adulthood, including transition to Older Adult Systems of Care. The service delivery components of ASOC should be organized by a case management team with the team as the single fixed point of responsibility, or a network of service providers with a single fixed point of responsibility.

Individual service provider and teams should come from multiple disciplines representative of all of the professional and paraprofessional disciplines including alcohol and drug. Services are accessible on a 24/7 basis and meet the client at the point of need – be that home, service site, shopping mall, street, etc. Services become truly seamless and accessible.

Access to and duration of services are based on individually determined consumer need and directed by consumers. The framework is designed to be dynamic so that individuals can enter/access services and re-enter or exit the system at any service point, depending on their needs. Re-entry is not a failure.

The standard ASOC is to be "Recovery" focused and is to be designed to provide services across five primary dimensions:

1. Mental Health Promotion, Wellness and Prevention Services:

In public mental health systems, mental health promotion and wellness, and prevention efforts are directed at the community at large. The mental health of communities and its residents are impacted by risk factors associated with stressors such as immigration, unemployment, homelessness, racism, sexism, ageism, and violence. Mental health promotion, wellness, and prevention services complement direct service and recovery activities by increasing community awareness about mental health issues and the resources available within Systems of Care as well as other community resources. These services are effective strategies for serving populations that have been historically underserved and difficult to engage. Mental health promotion, wellness, and prevention strategies should involve the members of the communities targeted, be educational in approach, and involve collaboration with other departmental agencies, such as human services, criminal justice, and the schools. Specific elements are as follows:

- Multi-cultural Anti-Stigma Education
- Behavioral Health screenings and Physical Health facilitation
- Community Education, Consultation and Training, i.e., law enforcement, public schools, housing resources, health care providers, as well as other collaborators. This includes public education campaign concerning adjustment to U.S. society, and dealing with acculturation stress and in-service training for primary health care physicians regarding screening and referral to the ASOC for ethnic populations with mental health problems
- Consumer and family training on how to access services

- Community Mental Health Resources (e.g., liaison with government and other organizations; problem solving around community mental health issues, manpower training)
- Mental health education programs for consumers and their family members (e.g., medications, substance abuse, smoking cessation)
- Friendship lines, hotlines, and warmlines
- Legislative advocacy on community mental health concerns
- Community forums and dialogues (e.g. suicide, race relations, drugs, mental health, domestic violence)
- Programs aimed at strengthening families and communities
- Peer-outreach

2. Access

- Outreach (mobile and in collaboration and partnership with the community)
- Initial assessments will be conducted in the primary language of the individual seeking services
- Written materials are available and understandable in the threshold languages and preferably, in all primary languages of the consumers
- Engagement. With attention to immediate need for a culture specific tradition of mental health supports to facilitate engagement (i.e., housing assistance, and physical health care) and includes culturally/and linguistically, age appropriate approaches.
- Identification of need and direction to culturally and linguistically appropriate services
- Advocacy to facilitate siting of services in areas of greatest need in the community
- Planning for self-managed approach to wellness
- Harm reduction for persons with co-occurring drug and alcohol problems which may include abstinence as a goal
- Transportation, location and hours of operation to ease access to services
- Physical facilities that are accessible, comfortable and inviting to all, including those persons of diverse cultural/ethnic backgrounds
- Family support and consultation as well as collaboration
- Caregiver support and consultation
- Exit Planning and successful linkage to other supports

3. Services that Support Recovery

Consumers use these services in tandem with or independent of Community Based Supports. The services may be provided by other agencies and coordinated by the case management team:

- Culturally, linguistically, and age appropriate assessment (to include support needs as well as an assessment like religion, spirituality, culture specific traditions of healing, housing, employment, education, and for dual diagnosis needs, such as alcohol or other drug problem, etc. Includes information and referral, requests for health care and other consultations.)
- Therapeutic and Recovery Oriented Services
  - Care management and Coordination (linkage, brokerage, and advocacy, SSI, Medi-Cal, food stamps, physical health care)
  - Consultation and Referral Services
  - Crisis Services (includes mobile crisis and crisis residential treatment)
  - Stabilization Services
  - Comprehensive services for recovery of persons with a dual disorders involving alcohol and/or drug abuse. Dual recovery services include engagement strategies, detoxification, residential care, and primary treatment
  - Psychotherapy/Counseling (Individual, Group, Family)
  - Mental Health Education
  - Forensic Mental Health Services
  - Correctional Mental Health Services including linkages with Probation, Department of Corrections and Juvenile Justice Services
  - Acute and Long Term Inpatient Care
  - A range of residential supported housing options as alternatives to institutional care
  - Skill Building (i.e., relapse prevention/WRAP, stress management, parenting)
  - Clinical Management related to somatic treatments, including collaboration with general medical providers
  - Medication initiation, Stabilization, and Maintenance
- Services Provided by Integrated Agencies and/or with Community Collaboration
  - Correctional mental health services
  - Supportive and Independent Housing
  - Supportive and Independent Employment (Including employment within the mental health system as care providers)
  - Supportive independent parenting
  - Supportive and Independent Education
  - Peer Supports (peer recovery network, drop-in centers, etc)
  - Family Support and Consultation
  - Caregiver Support and Consultation
  - Exit Planning and successful linkage to other supports
  - Regional Centers

4. Community Based Supports

Community based supports are provided and funded by community organizations. These services can be used by consumers in tandem with or independent of Recovery Oriented/Wellness Services, and are an essential element in ASOC design. The ASOC needs to have developed capacity for collaboration in order to facilitate relationships with organizations that provide or sponsor these services.

- Cultural and ethnic organizations
- Gender based organizations
- Sexual orientation based organizations
- Peer Support Networks
- Drop In Centers
- Adult Day Care Centers
- Freestanding Wellness Recovery Centers
- Family Supports
- Residential Care Facilities for Adults and Elderly
- Housing
- Employment
- Education
- Physical Health Care
- Legal Aid
- Faith Based Organizations and Spiritual Groups
- Dispute Resolution
- Economic and Community Development Departments
- Boards and Care alternatives (e.g., Augmented Board and Cares)
- Culturally Specific Traditional Healers
- Substance Abuse/Alcohol and Drug Treatment

5. Transition Services

Transition services into and out of ASOC services should be strong, specific, planned, and collaborative.

Transition Age Youth: Specific planning must occur between CSOC and ASOC to develop individual transitions for children who might need to access ASOC services. CSOC should consider transition plans at an appropriate age depending on the needs of the child. ASOC should be brought into case planning at age 16; if is appears that the child is likely to require adult services. The first priority for joint planning is to build a bridge for the young person to assume incremental responsibility for managing his or her own independence, as culturally appropriate using education, employment, and other community support services to assure recovery. Integrated CSOC and ASOC services should be available to the young person and his or her family and community, depending on individual needs, during the period 16-25. Services to young people during this period may include:

- Collaborative case plans with schools, community colleges, independent living programs, child welfare services, job training agencies, and linkages to community and individual benefit programs
- Service plans that identify the needs of the young person in the areas of employment, job training, health care, drug and alcohol abuse prevention, healthy relationships, information education, counseling, socialization, housing, and independent living skills
- Assistance with identifying the means for health insurance and educational linkages;
- Continuation of wraparound services with a goal toward independence, if it has been found beneficial by the child and family under CSOC
- Continuation of family or guardian participation in case planning for transition age youth
- Creating services that address specialized needs of youth who are at high risk of dropping out of mental health services
    - Peer support drop-in and other natural supportive centers
    - Specific outreach to youth who are homeless or at risk for becoming homeless
    - Services for youth who have had juvenile justice system involvement and are therefore at high-risk for becoming involved in the adult justice system

Transition Age Older Adults: Specific planning must occur between ASOC and OASOC to develop individual transitions for adults who might need to access the specialized services of a culturally and linguistically competent OASOC. The purpose of integrated joint planning is to build a bridge for the adult between adult services and the special needs of older adults. Integrated planning should begin based on the functionality of the individual, and the likelihood that the person will need the intensive linkage to health and support services available under OASOC. Services to adults during this period may include:

- Identification of specialized residential facilities for intensive care and security
- Identification of changing service needs, such as in-home services and appropriate dosages for medication
- Consultation to other agencies and providers with a focus on assisting with differential diagnosis and detection of depression and other mental disorders in older adults and others with complicating medical conditions and/or cognitive disorders
- Strengthened linkages to general health care providers
- Identification and involvement of family members in assessment of service needs of older adults
- Support resources and strategies for families for maintaining older adult in less restrictive levels of care

- Consultation and collaboration with alternative treatment modalities identified by older adults
- Consultation and collaboration with the faith community
- Identification of community based organizations to assist in the transitional process, such as home health agencies, older adult day treatment programs, in-home support and respite care for family members